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ACTION ON AGING LEGISLATION IN THE 97TH CONGRESS

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PREFACE

The 97th Congress produced an extraordinary volume of legislation of interest to older Americans. Very few of the programs that serve persons over 55 were untouched. The social security program was subject to minor changes even as more fundamental reforms were debated within the Congress and by the National Commission on Social Security Reform.

To help interested persons understand the major legislative initiatives undertaken during the last Congress, the Special Committee on Aging has asked the staff of the Congressional Research Service at the Library of Congress to compile this report. We would like to acknowledge in particular the work of Carol O'Shaughnessy of the CRS in producing this report.

JOHN HEINZ,
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JOHN GLENN,
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ACTION ON AGING LEGISLATION IN THE 97TH CONGRESS

Part 1

INTRODUCTION

This paper briefly summarizes selected major legislation in the 97th Congress affecting the elderly, including proposals actually enacted and those introduced during the session but not enacted. Due to the high volume of legislation affecting the elderly, not all laws or proposals are included; however, an attempt was made to highlight those which have, or would have, major impact on programs affecting this group. Due to the scope and complexity of much of the legislation, not all provisions of each law are included. Appropriations legislation is generally not included nor are Reagan administration budget proposals. Summaries of various legislative provisions were extracted from Congressional Research Service (CRS) issue briefs and other CRS source material. Additional references are provided for most areas.

The definition of elderly, for the purposes of eligibility for benefits or coverage, varies among programs. Some programs, such as medicare, make persons eligible at age 65, while other programs, such as the food stamp program, use age 60 as the criterion for special provisions for the elderly. Some employment programs use a lower age threshold, such as the community service employment program under the Older Americans Act, which uses age 55. The Age Discrimination in Employment Act protects persons from the ages of 40 to 70 from discriminatory practices in employment.

Generally, legislative action in the 97th Congress focused primarily on proposals to reduce the rate of spending and growth in certain Federal programs, produce cost savings, and/or reduce the scope of certain Federal programs. Three major bills oriented toward reductions in spending or program growth were enacted: The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35, enacted August 13, 1981); the Omnibus Budget Reconciliation Act of 1982 (Public Law 97–253, enacted September 8, 1982); and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97–248, enacted September 3, 1982).

These three laws contained changes in a variety of Federal programs including medicare, medicaid, supplemental security income, food stamps, pensions, civil service and railroad retirement programs, social services, energy assistance, and others. While many provisions in this legislation were oriented toward program restraint or reduction, certain provisions increased services or benefits for the elderly. For example, certain food stamp provisions liberalized some benefit rules

for the elderly, or exempted them from program reductions affecting other groups. While the medicare program increased certain beneficiary cost-sharing requirements, a new benefit—hospice care—was established as a separate provider category under the program. Similarly, under the medicaid program, States are now allowed to provide a range of community-based long-term care services, such as home care services, to persons who otherwise would need institutional care.

In addition to these laws, other legislation of importance to the elderly included the Older Americans Act Amendments of 1981 which reauthorized the program through fiscal year 1984 (Public Law 97–115, enacted December 29, 1981), and the Job Training Partnership Act which requires a jobs training program for disadvantaged older workers (Public Law 97–300, enacted October 13, 1982).

Discussion of social security financing issues was of continuing concern during the 97th Congress, but major legislative action awaited the recommendations of the National Commission on Social Security Reform, which completed its report in January 1983. Proposals to amend the Age Discrimination in Employment Act to eliminate the age 70 limitation for mandatory retirement were the subject of hearings in both Houses of Congress, but no final action was taken. Proposals to restructure and finance the current system of community-based long-term care services for the elderly and disabled, and to alter current tax deductions and credit provisions affecting the elderly were also considered.

Part 2

SELECTED LEGISLATION ENACTED IN THE 97TH CONGRESS

A. Health

1. MEDICARE [1]

Medicare (title XVIII of the Social Security Act) is a nationwide program that provides health insurance to most individuals age 65 and over, to certain disabled persons under 65, and to certain workers and their dependents who need kidney transplantation or dialysis. The program has uniform eligibility and benefit structure throughout the United States and protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts—the hospital insurance program (part A) and the supplementary medical insurance program (part B). Part A covers hospital services and post-hospital skilled nursing facility services. Part B covers physicians services and other medical care. Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. Part B is a voluntary program financed jointly through monthly premium charges on enrollees (currently $12.20) and by the Federal Government. In general, reimbursement under medicare is based on "reasonable costs" in the case of hospitals and other institutional providers and "reasonable charges" in the case of physicians and other noninstitutional suppliers.

The vast majority of persons reaching age 65 are automatically entitled to protection under medicare part A. Those over 65 not automatically covered may voluntarily obtain protection by paying monthly the full actuarial cost of such coverage (currently $113). In fiscal year 1983, an estimated 29 million aged and disabled persons will be covered by hospital insurance and supplementary medical insurance. Approximately 7.5 million persons will receive reimbursable hospital services and 19.4 million will receive reimbursable services under the supplementary insurance program.

Changes in medicare law during the 97th Congress occurred as the result of passage of two bills, the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) and the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248). In general, these laws are designed to reduce program spending through a combination of pro-

[1] For further information, see CRS Report No. 81–210 EPW, "Medicare and Medicaid Provisions of the Omnibus Budget Reconciliation Act of 1981," by Jennifer O'Sullivan; CRS Report No. 82–173 EPW, "Medicare and Medicaid Provisions of the Tax Equity and Fiscal Responsibility Act of 1982," by Jennifer O Sullivan and Glenn Markus; Issue Brief No. 82044, "Medicare," by Jennifer O Sullivan and Glenn Markus; and Issue Brief No. 82–42, "Hospice Care: A Federal Role," by Kay Reiss.

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visions which alter procedures for reimbursement of costs to health providers and which change beneficiary cost-sharing requirements.

The Omnibus Budget Reconciliation Act of 1981 included the following medicare provisions:

Changes in part A coinsurance and deductible amounts.—Part A coinsurance amounts applicable to hospital stays beyond 60 days and skilled nursing facility stays beyond 20 days are determined based on the amount of the inpatient hospital deductible in effect for the calendar year in which a spell of illness began. Public Law 97–35 modified the part A coinsurance provisions so that these amounts are based on the current calendar year's deductible.

The law also changed the manner in which the part A deductible and coinsurance amounts are calculated—a procedure which has the effect of increasing these amounts.

Increase in the part B deductible.—The law increased the part B deductible from $60 to $75, effective calendar year 1982, thereby raising the amount enrollees have to pay before program benefits will be paid.

The law also eliminated consideration of a previous year's medical expenses in determining calculation of the part B deductible amount, thereby reducing the amount of medical expenditures counted toward the deductible amount.

Elimination of occupational therapy as a basis for entitlement to home health services.—Previous law (Public Law 96–499) provided that the need for occupational therapy could qualify a person for home health benefits. The new law eliminated occupational therapy as a basis for initial entitlement to home health services; however, if an individual is otherwise entitled for these benefits (that is, on the basis of need for skilled nursing care, speech therapy, or physical therapy), eligibility for such benefits may be extended solely on the basis of continuing need for occupational therapy.

The law also included a number of changes in medicare reimbursement procedures, such as reducing the reimbursement limits established for inpatient general routine hospital operating costs and home health agency costs.

The Tax Equity and Fiscal Responsibility Act of 1982 included the following medicare provisions:

Increase in part B premium.—For a 2-year period beginning July 1, 1983, the part B premium paid by beneficiaries would be held at a constant percentage of total part B costs. As a result, the premium for individuals insured under part B will increase to $13.50 per month in July 1983. This is an increase over the previous law projection of $13.10. A similar increase is scheduled for July 1984.

Medicare as secondary payor for older workers choosing to be covered under group health plans.—Effective January 1, 1983, an amendment to the Age Discrimination in Employment Act requires employers to offer employees age 65 to 69 and their dependents the same health benefit plan offered to younger workers. Medicare would become the secondary payor to those plans for

such employees and their aged spouses. The decision whether to take this private coverage or select medicare as primary payor is voluntary on the part of the individual. Medicare payments would be reduced for any item of service furnished to an employee or spouse if the combined payment under medicare and the employer's health plan would otherwise exceed, for items and services reimbursed on a cost basis, their reasonable costs, or for items or services reimbursed on a charge basis, the higher of medicare's reasonable charge or the same amount allowable under the employer health benefits plan. In no case would medicare pay more than it would otherwise have paid in the absence of private coverage. Employers with less than 20 employees would be exempt from the provision.

Coverage of hospice care.—Under previous law medicare did not provide coverage for hospice care, although certain hospice-type services were reimbursed. Effective for the period November 1, 1983 to September 30, 1986, the law authorizes hospice care for terminally ill beneficiaries with life expectancy of 6 months or less. Hospices are established as a separate provider category under medicare. Under the new provision a beneficiary could elect to receive hospice care in lieu of most other benefits except those of the attending physician (if not employed by the hospice). Benefits would be available for two 90-day periods and one 30-day period and would include nursing care therapies, medical social services, homemaker-home health aide services, physicians' services, short-term inpatient care, outpatient drugs for pain relief, and respite care services. Beneficiary copayments are required for outpatient drugs and respite care.

Medicare coverage of Federal employees.—Under previous law, civilian Federal workers did not pay the part A hospital insurance tax nor did they earn part A coverage. Effective January 1, 1983, the law requires Federal civilian employees to pay the hospital insurance portion of the payroll tax, currently 1.3 percent; the Federal Government becomes liable for the employer portion. Thus, Federal workers will become eligible for part A protection on the same basis as other workers.

This change was proposed because about 80 percent of Federal employees earn medicare eligibility anyway through short-term employment in social security-covered jobs. Retirees who are eligible for medicare receive the same benefits regardless of how many years they paid the social security payroll tax. Many in Congress felt that Federal employees should pay the medicare tax for all of their working career, rather than for just the minimum period that they worked outside the government in social security-covered jobs.

Expansion of limits on hospital reimbursement.—Medicare reimburses hospitals on a "reasonable cost" basis. The law authorizes the Secretary of the Department of Health and Human Services (HHS) to set prospective limits on hospital costs and, under this authority, the Secretary has imposed limits on routine operating costs (i.e., bed, board, and routine nursing care). Public Law 97–248 expanded the limitations on hospitals to include, in addi-

tion to routine costs, all other inpatient hospital operating costs (e.g., laboratory, operating room, pharmacy, and special care units). Under the provision the Secretary may not recognize as "reasonable," operating costs which exceed a specified percentage of average cost per case for comparable hospitals.

Public Law 97-248 also established a 3-year target reimbursement system in order to create incentives for hospital cost control.

These provisions are not expected to affect beneficiary charges.

Single reimbursement limits for skilled nursing facilities and home health agencies.—Under previous law, the Secretary of HHS was authorized to set prospective limits on the costs of provider services under medicare on the basis of estimates of the costs necessary for the efficient delivery of needed health services. Allowable costs for services provided by skilled nursing facilities and by home health agencies generally vary depending on whether the skilled nursing home/home health services are delivered in hospital-based or in freestanding facilities. The law now requires the Secretary to establish a single limit for skilled nursing facilities and a single limit for home health agencies based on the cost experience of freestanding facilities.

The Tax Equity and Fiscal Responsibility Act also contained a number of other provisions with respect to provider reimbursement. For example, the law eliminated the salary cost differential for inpatient hospital nursing services which had previously been paid by medicare on the theory that medicare patients require more nursing care than the average patient.

2. MEDICAID [2]

The medicaid program (title XIX of the Social Security Act) is a Federal-State matching program providing medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. All States (except Arizona [3]), the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands participate in the program. Within specified Federal guidelines each State designs and administers its own program; thus, there is substantial variation among the States in terms of persons covered, services offered, and amount of payments for such services. The Federal Government's share of medicaid expenditures is tied to a formula inversely related to the per capita income of the State. Federal matching for services varies from 50 to 78 percent. In fiscal year 1982, an estimated 3.5 million of the medicaid program's 22.9 million recipients were elderly. They accounted for 37.5 percent of total program expenditures in fiscal year 1979.

Two laws amended the medicaid program during the 97th Congress—the Omnibus Budget Reconciliation Act of 1981 (Public Law

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[2] For further information, see CRS Report No. 81-210 EPW, "Medicare and Medicaid Provisions of the Omnibus Budget Reconciliation Act of 1981," by Jennifer O'Sullivan; CRS Report No. 82-173 EPW, "Medicare and Medicaid Provisions of the Tax Equity and Fiscal Responsibility Act of 1982," by Jennifer O'Sullivan and Glenn Markus; Issue Brief No. 82041, "Medicaid," by Jennifer O'Sullivan.

[3] Beginning Oct. 1, 1982, Arizona began implementation of a 3-year demonstration project under which a specified set of services are provided to the indigent on a prepaid basis.

97–35) and the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248). These laws contained a variety of provisions aimed at reducing Federal medicaid expenditures coupled with provisions giving States greater flexibility in implementing their medicaid plans.

The Omnibus Budget Reconciliation Act of 1981 included the following medicaid provisions:

Reduction in medicaid payments to States.—By law, the Federal Government helps States share in the cost of medicaid services by means of a variable matching formula that is periodically adjusted. The new law reduces the Federal matching payments to which a State is otherwise entitled by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. A State can lower the amount of its reduction by 1 percentage point for each of the following: (1) Operating a qualified hospital cost review program; (2) sustaining an unemployment rate exceeding 150 percent of the national average; and (3) demonstrating recoveries from fraud and abuse activities, and with respect to fiscal year 1982, third-party recoveries equal to 1 percent of Federal payments. The legislation also entitles a State to a dollar-for-dollar offset in its reductions if total Federal medicaid expenditures in a year fall below a specified target amount.

Modification in coverage provisions for the medically needy.—States have the option to provide medicaid to the medically needy, that is, persons whose incomes and resources are large enough to cover daily living expenses, according to income levels set by the State (within certain limits), but not large enough to pay for medical care, provided that they are aged, blind, disabled, or members of families with dependent children. Public Law 97–35 modified certain previous law requirements pertaining to coverage of the medically needy, thereby providing more flexibility to States in the design of their medicaid programs. Public Law 97–35 places the following requirements on medically needy programs: (1) If a State provides medically needy coverage to any group it must provide ambulatory services to children and prenatal and delivery services for pregnant women; (2) if a State provides institutional services for any medically needy group it must also provide ambulatory services for this population group; and (3) if the State provides medically needy coverage for persons in intermediate care facilities for the mentally retarded (ICF/MR's), it must offer all groups covered in its medically needy program the same mix of institutional and noninstitutional services as required under prior law.

Expanded home and community-based long-term care services.—In the past Federal matching payments have generally not been available under medicaid for nonmedical services rendered to program beneficiaries. Public Law 97–35 authorized the waiver of certain requirements in order to enable a State to provide expanded home and community-based services to individuals who have been determined to otherwise require skilled nursing facility (SNF) or intermediate care facility (ICF) services under medic-

aid. Services which may be provided under the waiver include: Case management; homemaker/home health aide; personal care services; adult day health; rehabilitation services; respite care services, and other services requested by the State and approved by the Secretary of the Department of Health and Human Services (HHS). Room and board services are excluded from coverage under the waiver.

The Secretary of HHS may not approve a waiver unless: The State provides for an evaluation of individuals' need for SNF or ICF services; individuals determined likely to require SNF or ICF care will be informed of the feasible alternatives available, at their choice, under the waiver; and the average per capita expenditure for an individual provided services under the waiver does not exceed the average per capita amount which would have been expended if the individual had to be institutionalized.

In addition to the above provisions, Public Law 97–35 provided States increased flexibility in administering their medicaid programs by permitting greater leeway in establishing reimbursement rates for hospital services, broadening the authority for agreement with prepaid health service entities, and allowing the Secretary of HHS to waive freedom of choice provisions and other State plan requirements.

The Tax Equity and Fiscal Responsibility Act of 1982 included the following medicaid provisions:

Nominal medicaid copayments.—Public Law 97–248 modified prior law requirements pertaining to cost-sharing. With certain exceptions States may now impose nominal copayments on all beneficiaries for all services. States are precluded from doing so for certain groups, including patients in skilled nursing and intermediate care facilities.

Modification of lien provisions.—Previous law prohibited States from imposing liens on a medicaid recipient's home prior to death. The law now permits States to attach the real property of certain medicaid recipients who are permanently institutionalized in nursing homes and other long-term care medical institutions. States could not foreclose on the lien until the home is sold or the recipient dies. They could recover the cost of medical assistance provided to the recipient only when the property is no longer needed by the recipient, spouse, sibling, or disabled or dependent children.

This provision also allows States to deny medicaid eligibility temporarily to patients in medical institutions who dispose of a home for less than fair market value, even though such disposal would not make them ineligible for supplemental security income.

Moratorium on nursing home regulations.—The law bars HHS from putting into effect proposed revised regulations governing the survey and certification of nursing homes for a 6-month period beginning on October 1, 1982. Proposed regulations were published on May 24, 1982. (In subsequent action Public Law 97–276, fiscal year 1983 continuing appropriations, extended the time period for public comment and congressional oversight of the regulations by an additional 120 days, until August 1, 1983.)

3. VETERANS' HEALTH CARE [4]

The Veterans Administration (VA) provides health care services in VA hospitals, domiciliary care facilities, nursing homes, and outpatient clinics. Services are provided on a contract basis in non-VA hospitals and community nursing homes, and on a grant basis in State veterans' home facilities. In general, VA medical care is provided to veterans according to a system of priorities, as follows: (1) Veterans requiring care for a service-connected disability; (2) veterans who are service-connected disabled needing care for a nonservice-connected disability; and (3) nonservice-connected disabled veterans who are unable to defray the cost of care elsewhere. About 25 percent of hospital patients discharged from VA hospitals in fiscal year 1981 were 65 years or over. The average age of veterans in nursing homes in fiscal year 1981 was 69.7 years; 61.3 percent were 65 years or over. The average age of veterans in domiciliaries was 59.8 years; almost 30 percent were 65 or over.

The Veterans Administration Health Care Programs Improvement and Extension Act (Public Law 97–251, enacted September 8, 1982) contained a number of provisions designed to improve the VA health care system and to assist health personnel. For example, the law gave the Administrator of the VA flexibility to improve the recruitment and retention of nursing personnel by establishing more flexible work schedules. The law expanded the VA's health professional scholarship program and provided for a 4-year extension in the authorization of appropriations for grants to States for the construction and renovation of State veterans' home health care facilities.

The law also provides that the Civilian Health and Medical Program-Veterans Administration (CHAMPVA)[5] beneficiaries who lose their CHAMPVA health care eligibility by virtue of becoming eligible for medicare benefits would become eligible again for CHAMPVA benefits once their medicare benefits have been exhausted.

4. OTHER HEALTH PROGRAMS

a. Health Block Grants to States [6]

The Department of Health and Human Services administers a wide array of health services and disease control programs that are utilized in part by the elderly. The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) created three [7] health block grant programs which consolidated a number of these separate categorical health programs. These services might be used by the elderly. The new programs are intended to give States more flexibility in determining the specific array and level of health services to be provided. The programs consolidated in the block grants are as follows:

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[4] For further information see CRS typed report, "Selected Legislation in the 97th Congress Relating to Services and Benefits for Veterans," by Barbara McClure.

[5] Medical care for the spouse, widow, or child of a veteran who has, or who has died as a result of, a service-connected disability.

[6] For further information, see CRS Report No. 82–109, "Health Block Grants," by Richard J. Price.

[7] A fourth block grant for maternal and child health programs was also established.

Preventive health and health services block grant.—Section 314(d) health incentive grants; hypertension control; fluoridation; rodent control; home health; [8] emergency medical services; health education/risk reduction; and rape crisis centers.

Alcohol and drug abuse and mental health services block grant.—Alcohol abuse formula and project grants and contracts; drug abuse formula and project grants and contracts; and Community Mental Health Centers Act; and Mental Health Systems Act.

Primary care block grant.—Community health centers.

Authority for these block grants was established in a new title XIX of the Public Health Service Act. The law provided for fiscal year 1982 authorization levels for each of the block grants which were different than the sum of the appropriations levels for the individual programs included in the block grants for the previous year. The fiscal year 1982 authorization level for the preventive health and health services block grant was $95 million—an increase of only 1.5 percent as compared with the fiscal year 1981 appropriations; for the alcohol and drug abuse and mental health services block grant, $491 million—a decrease of 5.5 percent as compared to the fiscal year 1981 appropriations; and for the primary care block grant, $286.5 million—a decrease of 11.5 percent as compared with the fiscal year 1981 appropriations.

The preventive health and the alcohol, drug abuse, and the mental health block grants became effective October 1, 1981. The primary care block grant became effective October 1, 1982.

b. Home Health Services

In 1976, the Public Health Service (PHS) Act authorized a program of grants to encourage the development and expansion of home health services in areas where there was an insufficient supply of these services. Funds were authorized with the purpose of assisting agencies and organizations to meet the initial costs of establishing and operating home health agencies or to expand such services. With the passage of the Omnibus Budget Reconciliation Act in 1981 (Public Law 97–35), a number of separately authorized health services programs were incorporated into block grant programs to States (described in the preceding section). The home health program authorized in 1976 was folded into the preventive health and health services block grant program.

During the 97th Congress, a bill to expand home health services, S. 234, the Community Home Health Services Act of 1981, was considered by Congress (see section on legislation introduced but not enacted). Although S. 234, in its original form was not enacted, portions of the bill relating to PHS grants, loans, and contracts for expansion of home health services in underserved areas were included in the Orphan Drug Act (Public Law 97–414, signed January 4, 1983). Passage of these provisions has the effect of reestablishing a separate categorical program for development of home health services some-

[8] A similar program was reestablished as a categorical program in subsequent legislation. See section on "Home Health Services."

what similar in intent to the program originally authorized under the PHS Act in 1976.

The Orphan Drug Act's provisions relating to home health services (section 6 of the law) authorized grants to public and nonprofit private entities and loans to proprietary entities to encourage the establishment and operation of home health services in areas where such services are inadequate or not readily accessible. In the award of funds the law requires the Secretary of Health and Human Services (HHS) to consider the relative needs of States, to give preference to areas where a high proportion of the population in need of services is elderly, medically indigent, or disabled, and to give special consideration to areas with inadequate transportation systems to access such services. The law authorized $5 million for each of fiscal year 1983 and fiscal year 1984.

The law also authorized grants or contracts to support training programs for paraprofessional personnel who provide home health services. The law authorized $2 million for each of fiscal year 1983 and fiscal year 1984 for this purpose.

In addition to these provisions, the law required the Secretary of HHS to conduct and submit to Congress, a series of studies relating to home health services. These studies include evaluation of the impact of funds awarded under the law; the extent to which standards have been applied to the training of home health service personnel; efforts made by the Department of HHS to stem fraud and abuse in home health services programs under medicare and medicaid; the results of research evaluating home and community-based health services and recommendations to improve such services; and analysis of alternative reimbursement methodologies for home health services. The law also required the Secretary to conduct demonstration projects to identify persons at risk of institutionalization who could more effectively be served through home health services, and which include the development of alternative ways to reimburse home health agencies.

B. Income

1. Social Security [9]

The old-age, survivors, and disability insurance (OASDI) program (authorized under title II of the Social Security Act) provides monthly cash benefits to retired workers aged 62 and older, to disabled workers, and to the dependents and survivors of insured workers. Workers become insured for social security benefits through employment in jobs covered by the social security system. More than 9 out of 10 jobs are now covered by social security, and as of August 1, 1982, 94 percent—about 24½ million—of the 26 million people aged 65 and over were eligible for monthly cash benefits under social security. Ninety-seven percent of the elderly population are eligible for benefits under social security or some other Federal retirement system. As of August 1, 1982, a total of 24,674,000 elderly (65 and older) persons received cash payments from social security.

[9] For further information see CRS Issue Brief No. 81036, "Social Security: An Overview of President Reagan's 1981 Proposals," by David Koitz and Nancy Miller.

Although several provisions to amend the social security law were enacted during the 97th Congress, primarily by the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35), major congressional action on social security financing awaited receipt of the report of the bipartisan National Commission on Social Security Reform appointed by President Reagan in 1981.

The following social security provisions were enacted during the 97th Congress:

Elimination of the minimum benefit.—The Omnibus Budget Reconciliation Act of 1981 eliminated the minimum social security benefit of $122 for all current and future beneficiaries who would have been eligible for less than that amount under the regular benefit calculations. However, this legislation was later modified by Public Law 97–123 (enacted December 29, 1981). Under Public Law 97–123, beneficiaries who first became eligible for social security benefits prior to January 1, 1982, may continue to receive the minimum benefit, but newly eligible beneficiaries will receive a benefit based on the regular benefit formula, even if that benefit is less than $122 per month. An exception was made for members of religious orders who are under a vow of poverty. These persons may become eligible for the minimum benefit until January 1, 1992.

Modification of lump-sum death benefit.—Under prior law, a one-time death benefit payment of $255 was made to the surviving spouse of a deceased worker or to some other person or institution (e.g., funeral home) incurring expenses in connection with the deceased worker's funeral. The lump-sum death benefit could be paid whether or not regular monthly cash benefits were payable to survivors of the deceased worker. Public Law 97–35 restricted payment of the lump-sum death benefit to cases where there is a surviving spouse or a child entitled to monthly benefits. (This provision is effective for deaths after August 1981.)

Delay in month of entitlement.—Under prior law, social security benefits were payable for the entire month during which the beneficiary first met all requirements for eligibility. Public Law 97–35 contained a provision which delays eligibility for social security benefits for a worker retiring at age 62, and his dependents, until the first full month after all factors of eligibility are met.

Retirement test exempt age.—Public Law 97–35 delayed the date when the exempt age for the retirement test is lowered from 72 to 70 years. The retirement test (also referred to as the earnings test) in effect limits the amount of earnings from either wages or self-employment that a person can receive and still be eligible for full social security benefits. Under prior law all workers 70 years and over would have become exempt from the retirement earnings test in 1982. Public Law 97–35 moved the date so that the exempt age remained at 72 until January 1983, when it was dropped to 70 years.

2. SUPPLEMENTAL SECURITY INCOME [10]

The supplemental security income (SSI) program provides monthly cash payments in accordance with uniform, nationwide eligibility requirement to persons with limited income, who are aged 65 and over, blind, or disabled. Established by the 1972 amendments to the Social Security Act, the program is available in the 50 States, the District of Columbia, and the Northern Mariana Islands. Puerto Rico, Guam, and the Virgin Islands still operate the prior programs of Federal-State cash aid for needy adults that SSI replaced elsewhere. In 1981, there were 4.1 million SSI recipients of whom 40 percent were aged and 60 percent were blind or disabled.

The Omnibus Budget Reconciliation Act of 1981 included the following provisions:

—In determining the SSI benefit amount, an applicant's prior month's income is taken into account, replacing the previous law requirement of considering a prospective quarterly estimate of income.

—State vocational rehabilitation agencies are authorized to receive reimbursement only for services provided to SSI recipients who subsequently perform substantial gainful activity which lasts for a continuous period of 9 months.

The Tax Equity and Fiscal Responsibility Act of 1982 included the following provisions:

—SSI benefits are prorated from the date of application, or the date of eligibility, whichever is later, rather than the previous law requirement of paying benefits from the first day of the month in which the recipient became eligible.

—The monthly benefit payment is rounded down to the next lower dollar rather than to the next higher 10 cents, as provided by previous law.

—Up to $1,500 in assets for each individual and spouse can be excluded from consideration in determining SSI eligibility if such funds are designated for a burial plot. However, the amount excluded as a burial fund or plot must be reduced by the amount of any life insurance policies held by the individual. Thus, the exclusion of burial funds gives SSI recipients an alternative to life insurance. Previous law had counted burial funds or plots as assets in determining SSI eligibility status.

3. SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME DISABILITY PROGRAMS [11]

The social security disability insurance (DI) program is the Nation's primary source of income replacement for workers (and their families) who are unable to work due to a disabling condition. It

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[10] For further information see Issue Brief No. 82048, "Supplemental Security Income FY83 Budget Proposals," by Carmen Solomon.

[11] For further information see CRS Issue Brief No. 82078, "Social Security: The Ongoing Review of Disability Cases," by David Koitz and Nancy Miller.

serves about 4.1 million beneficiaries (2.6 million of whom are disabled workers in October 1982). About 300,000 disabled workers were awarded benefits in calendar 1982. Among workers awarded benefits in 1975, the average age was 55.6 years; 44 percent had been employed in blue-collar occupations requiring some type of physical labor; and 60 percent had less than a high school education.

To be eligible for DI benefits, a worker must be covered by social security and be "disability" insured. To be fully insured for life, a worker must have credit for working 40 calendar quarters in covered employment. To be disability insured, the worker must have 20 quarters of coverage in the 40 quarters preceding the onset of disability (there are exceptions for younger workers and the blind).

The supplemental security income disability program served approximately 2.3 million SSI disability recipients in July 1982. In general, the SSI program defines disabled in the same manner as the DI program; in addition, an individual must be able to meet a "means test."

Congress reviewed the disability program during the 97th Congress in response to a concern regarding an increase in the percentage of disability reexaminations begun by the Social Security Administration (SSA) in 1981, which resulted in benefit terminations. Legislation to soften the effect on beneficiaries of terminating them from DI and SSI disability rolls was approved by Congress during the last days of the 97th Congress (Public Law 97–445, signed January 12, 1983). This legislation included the following provisions:

—DI benefits will be continued for terminated beneficiaries until a decision on their appeal has been reached by an administrative law judge, but not beyond June 1984 and not for terminations occurring after September 30, 1983. Beneficiaries whose appeals were pending at the time of enactment as well as those whose benefits were terminated subsequent to enactment (but before October 1, 1983) would be eligible to elect the special benefits paid during appeal. Benefits may be paid under this provision beginning in the month following the month of enactment. Benefits paid during appeal would have to be subject to recoupment as overpayments if the termination decision were ultimately upheld on appeal.

—The Secretary of Health and Human Services is authorized to waive, on a State-by-State basis, the statutory requirement (from 1980 disability amendments) that all nonpermanently disabled beneficiaries be subject to a continuing disability review at least once every 3 years. Waivers could be granted only when the Secretary finds that the State agency has made a good faith effort to process case reviews in a timely fashion.

—No later than January 1, 1984, State agencies or SSA are required to conduct an evidentiary hearing, with an opportunity for an in-person appearance by the terminated beneficiary, as a part of the reconsideration level of appeal in all DI benefit termination cases.

4. CIVIL SERVICE RETIREMENT SYSTEM [12]

The civil service retirement system (CSRS) is a staff retirement plan for Federal civilian personnel. CSRS is the largest and oldest retirement program for employees in the competitive civil service. In fiscal year 1982, CSRS covered over 2.7 million workers and paid approximately $19.4 billion in benefits to 1.8 million retirees and survivors. Employees completing at least 5 years of Federal employment are eligible to receive benefits provided they have satisfied retirement criteria and have contributed all required amounts for any credited years. The system is financed by a combination of employee contributions and Government payments to the civil service retirement and disability fund.

Annuity payments under CSRS are adjusted according to changes in the Consumer Price Index (CPI) which occurred during the most recent previous calendar year. A number of changes in payment provisions relating to the cost-of-living adjustments (COLA's) to CSRS annuity payments were made during the 97th Congress.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) provided that the cost-of-living adjustment for CSRS annuities would be adjusted at an annual rather than on a semiannual basis as required under prior law. As a result of Public Law 97–35, COLA's were to be applied each March 1, with the change reflected in checks issued the following month. However, beginning in 1983, the month for application of the COLA will change as provided by the Omnibus Budget Reconciliation Act of 1982 (Public Law 97–253). Public Law 97–253 delayed all Federal COLA's by 1 month for each of the next 3 fiscal years. Thus, the new law provides that the COLA will be applied in April of fiscal year 1983, May of fiscal year 1984, and June of fiscal year 1985, with annuity payments reflecting those increases first issued the following month. Under this law the measuring period for the CPI will continue to be the calendar year prior to the adjustment.

Public Law 97–253 also limited COLA to all Federal annuitants under age 62 to one-half of the "assumed increase" in the CPI for the year, and placed the inflation rates in the law (6.6 percent for fiscal year 1983; 7.2 percent for fiscal year 1984; and 6.6 percent for fiscal year 1985). Under this provision, retirees under age 62 (except for annuitants retired for disability) will receive one-half of the assumed CPI change, plus any excess over that projection. Thus, for fiscal year 1983, retirees under age 62 are to receive a minimum of 3.3 percent COLA for any CPI change up to 6.6 percent, and an additional percentage point increase equal to any CPI change greater than 6.6 percent. Survivors and annuitants retired for disability will receive the full COLA.

Public Law 97–253 made a number of other changes in CSRS benefits, including rounding down benefit computations to the next whole dollar, and restricting early retirement provisions.

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[12] For further information see CRS Issue Brief No. 82088, "Civil Service Retirement: FY83 Budget Proposals" by Dennis Snook.

5. MILITARY RETIREMENT SYSTEM [13]

The military retirement system covers members of the regular and reserve military and their surviving dependents. It consists of three major elements—disability retirement, nondisability retirement, and survivor benefits. Expenditures for these three elements will total about $16.4 billion in fiscal year 1983, serving about 1.4 million beneficiaries.

The Omnibus Budget Reconciliation Acts of 1981 and 1982 (Public Law 97–35 and Public Law 97–253) made the same changes in the cost-of-living adjustments (COLA's) for the military retirement system as provided in the civil service retirement system as described in the preceding section. Specifically, the Omnibus Budget Reconciliation Act of 1981 replaced semiannual COLA's as provided under prior law with annual COLA's. The Omnibus Budget Reconciliation Act of 1982 placed a ceiling on COLA's in fiscal years 1983, 1984, and 1985 for retirees under age 62 except those receiving disability-retired pay. The ceiling is one-half of an assumed percentage increase in the CPI as stated in the act for each fiscal year, plus any amount by which the actual increase in the CPI might exceed the assumed increase. (The assumed increases in the CPI are 6.6 percent for fiscal year 1983, 7.2 percent for fiscal year 1984, and 6.6 percent for fiscal year 1985.) As in the civil service retirement system, COLA's for military retirement will be delayed by 1 month for fiscal years 1983, 1984, and 1985.

In addition, this legislation required that the amount of each COLA for a military retiree working in the Federal Government be deducted from his civilian salary. This latter provision has no age restriction, but exempts persons receiving disability retired pay or serving as Federal judges.

6. RAILROAD RETIREMENT SYSTEM [14]

The railroad retirement system (RRS) is a federally legislated retirement system providing retirement, survivor, and disability protection for workers with at least 10 years of railroad employment. The system is financed by employee and employer contributions to a trust fund and by reimbursement from the social security system for obligations of that system paid by RRS. In addition, some RRS beneficiaries receive a benefit paid from a separate account financed directly from general revenue appropriations. The benefit, called a "dual windfall benefit," is paid to a closed group of persons who acquired certain benefit rights from both RRS and social security prior to 1975. Altogether, RRS distributed approximately $5.3 billion in fiscal year 1981, while receiving $4.7 billion in revenues. As a result of changes in the first session of the 97th Congress, this deficit of $600 million had been estimated to fall to $200 million in fiscal year 1982. However, because of the loss of 90,000 rail jobs since November 1980, the deficit has actually increased to $660 million for fiscal year 1982.

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[13] For further information see CRS Archived Issue Brief No. 82034, "Defense Budget—FY83—Manpower," by Paul Zinsmeister.

[14] For further information, see CRS Issue Brief No. 82021, "Railroad Retirement: Revising the Federal Role," by Dennis Snook.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) and the Economic Recovery Tax Act of 1981 (Public Law 97–34, enacted August 13, 1981) contained modifications in the RRS aimed at assuring the continued solvency of the system.

The Omnibus Budget Reconciliation Act made certain benefit changes including changes in the "dual windwall" benefit rights of employees and retirees who had been grandfathered for these rights when the RRS was reorganized in 1974, as well as modifications in cost-of-living adjustments (COLA's). Under the new law, "dual windfall" benefits no longer are adjusted at award for the compounded value of any social security COLA's occurring since January 1975, and the date of retirement, but are limited to compounded social security COLA's between January 1, 1975 and January 1, 1982. These benefits continue to be frozen at retirement and thus have a diminishing real value over time in the face of continuing inflation. In addition, Congress ended any additional awards of "dual windfall" benefits to spouses. These two changes ended most uncertainty about future "dual windfall" costs by eliminating any adjustments for inflation and by clarifying the number of eligible beneficiaries.

Public Law 97–35 for the first time made benefits available to divorced spouses, remarried widows, and surviving divorced mothers, modified the benefit formula for new retirees, and installed permanent annual cost-of-living adjustments (32.5 percent of CPI changes) for a portion of the benefit paid to survivors. The major portion continues to be annually adjusted at 100 percent of CPI changes. The new CPI formula for survivor benefits is that already used for benefits to retirees.

In the Economic Recovery Tax Act, Congress increased the payroll tax on employers 2.25 percent (to 11.75 percent) and added a 2-percent tax on employee pay for the first time.

7. FOOD STAMPS [15]

The food stamp program is designed to enable low-income households to buy a nutritionally adequate low-cost diet by spending a specific portion of their "counted" cash income (income determined after allowable deductions) on food. Food stamp benefits make up the difference between that amount and the sum deemed sufficient to buy an adequate low-cost diet—that is, the cost of the Department of Agriculture's "thrifty food plan." Eligibility requirements for food stamps include income limits, liquid assets limitations, and work registration requirements. The eligibility requirements and benefit rules for households with elderly or disabled persons are substantially more liberal than for households without such persons. For example, these groups are allowed to deduct medical expenses when eligibility and benefits are calculated and they have no gross income test applied in judging their eligibility.

[15] For further information, see CRS Issue Brief No. 82076, "Food Stamps: 1982 Legislation," by Joe Richardson; CRS Typed Report, "Food Stamp Program Budget Reductions in the Omnibus Budget Reconciliation Act of 1981," by Joe Richardson, and CRS Typed Report "Brief Summary of Food Program Changes Made by the Agriculture and Food Act of 1981; P.L. 97–98," by Joe Richardson.

Approximately 20.5 million persons receive food stamps each month. Another 1.7 million persons in Puerto Rico receive nutrition assistance in the form of cash aid under Puerto Rico's federally funded nutrition assistance block grant. About 11 percent of food stamp recipients are age 60 or over, and more than half of these 2.2 million persons live alone.

Three laws amended the Food Stamp Act during the 97th Congress—the Omnibus Budget Reconciliation Act of 1981, the Agriculture and Food Act of 1981, and the Omnibus Budget Reconciliation Act of 1982. These laws made numerous changes aimed at stemming the growth of Federal food stamp expenditures. In general, savings to the program are to be achieved by delaying and making smaller inflation indexing of benefits, imposing a gross income eligibility limit on most applicants, and a series of minor changes such as prorating first-month benefits according to the date of application. The elderly, as well as certain disabled persons, were exempted from some of the program changes which altered eligibility status for other groups and benefited from certain provisions to liberalize food stamp benefit rules as noted below.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) postponed, and made smaller, benefit adjustments scheduled in 1982 and future years. It also contained a number of changes in administrative rules and eligibility requirements. For example, the law now requires that first-month food stamp benefits be adjusted to reflect the date of application, ending the previous practice of granting full first-month benefits regardless of when in the month an applicant applies. The law also requires that, effective October 1983, income eligibility be determined by reviewing an individual's prior month's income rather than estimating income for the current month and future months as provided by prior law. The law removed the requirement for State "outreach" activities intended to inform people about the availability and benefits of the food stamp program. It also prohibited Federal funding for this activity which previously was funded at 50 percent of the costs. While the law established new lower limits on the amount of gross income an otherwise eligible household may have to receive benefits (130 percent of the official Federal poverty levels), households with elderly or disabled members were exempted from this limitation.

The Agriculture and Food Act of 1981 (Public Law 97–98, enacted December 22, 1981) extended the authorization of appropriations for the food stamp program through September 30, 1982, and set its authorization at $11.3 billion in fiscal year 1982. This law also eliminated the earlier delayed inflation adjustment to food stamp benefits during fiscal year 1982. Inflation adjustments were rescheduled to occur annually each October. Under prior law benefit adjustments were to occur in April 1982, July 1983, and each October thereafter.

Another provision affecting the elderly contained in the Agriculture and Food Act permits continuation of existing pilot projects where elderly food stamp recipients and those who are also supplemental

security income recipients receive their benefit in cash, through fiscal year 1985, at State option. It also authorizes new types of pilot projects including those in which:

—Households with elderly members, or aid to families with dependent children (AFDC) or SSI recipients, may receive a standardized food stamp benefit in cash; and

—Elderly persons can receive federally donated commodities through the commodity supplemental food program now serving low-income pregnant women and young children.

The Omnibus Budget Reconciliation Act of 1982 included the following provisions *liberalizing* food stamp benefit rules for the elderly and disabled:

—Increases in the cash income of food stamp recipients due to scheduled July inflation adjustments to social security, SSI, railroad retirement, and veterans' payments will not be counted as income in the calculation of food stamp benefits until food stamp benefit levels are indexed for food price inflation in October. This provision coordinates the timing of food stamp inflation adjustments with those in the major Federal cash benefit programs for the elderly and disabled and prevents a 3-month decrease in food stamp benefits that would otherwise occur between July and October.

—The definition of "disabled" was expanded to include severely disabled veterans and their disabled survivors who, under prior law, were not accorded the more liberal eligibility and benefit rules applied to disabled recipients of social security or SSI payments.

—Elderly persons who cannot purchase and prepare food separately because of a disability are to be allowed to apply as a household separate from the rest of their residential unit, provided the household in which they live has a gross income of less than 165 percent of the Federal poverty level. This provision will make eligibility more likely for these persons since they would be applying as individuals rather than as part of their residential unit.

The following provisions aimed at *reducing* Federal food stamp expenditures were included as part of the Reconciliation Act of 1982:

—Changes were again made in inflation adjustment of benefits, including a requirement that, after each October's inflation adjustment, benefit levels be reduced by 1 percent, through fiscal year 1985, and delaying inflation indexation of various food stamp deductions (amounts subtracted from income when determining eligibility).

—Benefits and inflation adjustments will be rounded down to the next whole dollar rather than rounded to the nearest dollar as provided by prior law.

—The Secretary of Agriculture may limit house-to-house trade routes (e.g., mobile markets) authorized to accept food stamps to those which are determined to be reasonably necessary to provide access to food by recipient households provided it is found that unlimited approval of these routes damages the integrity of the food stamp program.

8. LOW-INCOME ENERGY ASSISTANCE

The low-income energy assistance program (LIEAP) provides grants to States for the purpose of financial assistance to low-income households with home energy costs that are excessive in relation to household income. Although the States set actual eligibility guidelines, they are limited under Federal law to provide assistance (with Federal funds) to households with a categorically eligible member or with incomes below either 150 percent of the poverty level or 60 percent of a State's median income adjusted for family size. Categorical eligibility is based on receipt of payments under AFDC or SSI, food stamps, or veterans' pensions. Of the 4.6 million households which applied and received assistance (i.e., as opposed to those households which automatically received assistance under State guidelines for categorical eligibility) in fiscal year 1981, about 39 percent had at least one elderly member. The law requires States to assure that outreach activities aimed at households with an elderly or handicapped member will be conducted.

The Low-Income Home Energy Act of 1981 (enacted as title XXVI of the Omnibus Budget ReconciliationAct of 1981) authorized grants to States for LIEAP for fiscal years 1982, 1983, and 1984 at $1.875 billion each year. The program is 100 percent federally funded. Up to 15 percent of a State's allotment may be used for weatherization. Assistance may be provided for either heating or cooling assistance. States are required to make assurance that a "reasonable" amount of their grant will be used for energy-related emergency assistance.

9. VETERANS' PENSIONS AND COMPENSATION [16]

Under the veterans' pension program, monthly benefits are paid to low-income wartime veterans who are permanently and totally disabled from nonservice-connected causes or who are age 65 or over. Veterans 65 years of age or older who are not working are considered permanently and totally disabled. Survivors of wartime service veterans also may qualifiy for pension benefits based on financial need. To be eligible for the pension program, a veteran must have been discharged from the military under conditions other than dishonorable after 90 days or more of service (or separated from service earlier because of a service-connected disability) including at least 1 day of wartime service. Automatic cost-of-living adjustments (COLA's) are provided annually in the same amount and at the same time as social security benefits. Beneficiaries are estimated at 1.8 million persons in fiscal year 1983.

Under the veterans' compensation program, monthly benefits are paid to veterans who became disabled, or whose disabilities were aggravated, while serving on active duty in the Armed Forces. The amount of compensation payable varies according to the veteran's degree of disability as determined by the Veterans Administration. Generally, disability compensation is based on the degree of an indi-

[16] For further information, see CRS typed report "Selected Legislation in the 97th Congress Relating to Services and Benefits for Veterans" by Barbara McClure.

vidual's reduced earning capacity in civilian occupations. The individuals are rated from 10 percent (zero in certain cases) through 100-percent disabled, and are compensated accordingly. Unlike VA pension benefits, compensation rates are not automatically increased each year. Congress generally passes legislation to raise compensation rates annually in accord with cost-of-living increases. An estimated 2.6 million veterans and their survivors are expected to receive compensation benefits in fiscal year 1983. About 30 percent of these recipients will be 65 years of age or older.

The Veterans' Disability Compensation, Housing, and Memorial Benefits Amendments of 1981 (Public Law 97–66, enacted October 17, 1981) provided for adjustments in the COLA for disability compensation benefits by a variable rate, depending upon the degree of disability, with veterans rated 100-percent disabled receiving an 11.2 percent increase. This law also increased by 11.2 percent the COLA for dependency and indemnity compensation benefits payable to survivors of veterans who have died from service-incurred causes, and for the annual clothing allowance for eligible veterans. These COLA's were effective for fiscal year 1982.

The Omnibus Budget Reconciliation Act of 1982 (Public Law 97–253) made a number of changes in existing law designed to reduce spending for benefits and services in fiscal year 1983, including the following:

Rounding down of benefits.—Under prior law, veterans' pension or compensation benefit amounts were rounded up or down to the nearest dollar. Under the new laws, benefits will be rounded down to the nearest lower dollar effective with the next cost-of-living adjustment. For pensions, benefit amounts will be rounded down in June 1983; for disability compensation, benefit amounts were rounded down with the fiscal year 1983 COLA, effective October 1982.

Deferral in commencement of benefits.—Under prior law, pension or compensation benefit amounts were paid effective the month in which the award was granted. Under the new law benefit payment will be deferred until the first full month following the month in which the benefit is granted.

Benefits reductions due to dependency status changes.—Under prior law, pension or compensation benefit amounts were adjusted due to changes in dependency status on the last day of the year in which they occurred. Under the new law, reductions in benefit amounts will be effective at the end of the month in which the change occurs.

The Veterans' Compensation, Education and Employment Amendments of 1982 (Public Law 97–306, enacted October 14, 1982) provided for an increase of 7.4 percent in the COLA for disability compensation benefits, dependency and indemnity compensation for surviving spouses and children, and for clothing allowances for certain disabled veterans. These COLA's are effective for fiscal year 1983. This law also increased compensation rates for certain blind veterans. It also reduced from 2 years to 180 days the time allowed to appeal a notice to repay overpayments of veterans' benefits.

10. PRIVATE PENSIONS

The Employee Retirement Income Security Act of 1974 (ERISA) is designed to protect the interests of participants and beneficiaries of most private sector employee benefit plans. Approximately 50 million participants and beneficiaries are covered by a half-million pension plans with assets totaling about $500 billion.

ERISA does not require that employers provide plans, but those that do must meet its rules. ERISA sets minimum standards that plans must meet in regard to:

—Who must be covered (participation).
—How long a person has to work to be entitled to a pension (vesting); and
—How much must be set aside each year to provide pensions when they are due (funding).

ERISA also requires that pension funds be handled prudently and in the best interests of the participants and beneficiaries (fiduciary standards), and that participants be informed of their rights and that there is adequate disclosure of the plan's financial activities (reporting and disclosure requirements). ERISA also established a program to guarantee the payment of pension benefits in case a plan is ended or an employer becomes insolvent (pension benefit insurance).

As part of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248), Congress made significant changes in the tax provisions affecting employee benefit plans. They included reducing the amount of tax-deductible contributions that may be made to corporate pension plans and eliminating distinctions between corporate and noncorporate plans. The maximum dollar limits on pension contributions and benefits were reduced. The maximum dollar limit on annual additions under defined contribution plans was changed from the lesser of 25 percent of compensation or $45,475, to the lesser of 25 percent of compensation or $30,000. The maximum dollar limit on the annual benefit payable under defined benefit plans is changed from the lesser of 100 percent of compensation or $136,425, to the lesser of 100 percent of compensation or $90,000.

This law also established parity between corporate and noncorporate plans. Special rules for Keogh plans for the self-employed were repealed to place them on equal footing with corporate plans, including the $30,000 contribution and $90,000 benefit limitations.

Stricter rules were established for so-called "top-heavy" plans—plans under which more than 60 percent of the accrued benefits (or contributions) are provided for key employees. These requirements include accelerated vesting schedules and a minimum benefit.

C. Social Services

1. OLDER AMERICANS ACT (ADMINISTRATION ON AGING PROGRAMS) [17]

The Older Americans Act sets out 10 national policy goals aimed at improving the lives of older Americans and providing the legislative

[17] For further information, see CRS Typed Report, "Older Americans Act Legislation in the 97th Congress," by Carol O'Shaughnessy, Feb. 24, 1982, and CRS Report No. 82–158 "The Older Americans Act of 1965: Major Provisions, As Amended, and Development of Selected Major Provisions, 1965–1981," by Evelyn Tager, updated by Carol O'Shaughnessy, Sept. 17, 1982.

basis for the creation of the Administration on Aging (AoA). The largest program under the act, title III, authorizes development of programs to assist older persons (especially those with the greatest social or economic needs) through formula grants to States, which in turn award funds to area agencies on aging, for community planning and supportive, nutrition, and senior center services. In fiscal year 1981, there were approximately 677 area agencies on aging, 7,926 social service providers, 12,915 congregate nutrition service sites, and 3,373 home-delivered meals providers supported by title III. Approximately 8.9 million older persons were social service participants; over 2.8 million persons were served by the congregate meals program, and 0.6 million persons served by the home-delivered meals program.

Other Older Americans Act programs support research, demonstration, and training programs, and grants to Indian tribal organizations for social and nutrition services for older Indians. The community service employment program (title V of the act) is administered by the Department of Labor (see "Employment" section).

The act was recently reauthorized for 3 years through fiscal year 1984 by the Older Americans Act Amendments of 1981 (Public Law 97–115, enacted December 29, 1981). The law made a number of modifications designed to give State and area agencies on aging more flexibility in the administration of the grant program for supportive. senior centers and nutrition services under title III. For example, the law amended the prior law provision requiring an area agency to expend a specific amount of title III funds on certain priority services (access, in-home, and legal services) and now requires only that each area agency expend "an adequate portion" of its supportive services allotment on these services. The law also added a provision allowing a State to transfer up to 20 percent of its allotment for supportive and nutrition services from one allotment to the other. The law also allowed State and area agencies to develop their respective plans on aging on a 2-, 3-, or 4-year basis, at State option, rather than on a 3-year basis as required by prior law.

The amendments consolidated the authorization for certain training, research, and demonstration activities. They eliminated a prior law requirement for a funding set aside for legal service projects, but required the Commissioner to conduct projects to assist State and area agencies in providing legal services to older persons. The law also eliminated an age definition for older Indians under the program of grants to Indian tribal organizations and eliminated the authorization for the Nationalclearing House for the Aging.

2. SOCIAL SERVICES BLOCK GRANT PROGRAM [18]

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) created the social services block grant (SSBG) program which succeeded a similar but somewhat more restrictive program of social services grants to States under title XX of the Social Security Act. The title XX program has been a source of funds for a variety of social services for the elderly in many States. The SSBG program consolidated the social services and training programs which were pre-

[18] For further information see CRS Archived Mini Brief No. 82211, "Social and Community Services Block Grants: FY83 Budget Issues," by Karen Spar, and CRS Archived Issue Brief 81102, "Social Services Block Grant," by Karen Spar.

viously separately authorized and eliminated a number of prior law requirements. For example, States no longer are required to provide a minimum level of services to welfare recipients or to target services on specified groups. The law allows States to design their own mix of services and to establish their own eligibility criteria. Federal requirements for income eligibility standards and non-Federal matching requirements were eliminated.

Public Law 97–35 provided for a 20-percent funding reduction in social services from fiscal year 1981 to fiscal year 1982 and established the following authorization levels for the SSBG: $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized.

3. COMMUNITY SERVICES BLOCK GRANT PROGRAM [19]

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) created the community services block grant (CSBG) program replacing the former Community Services Administration which was abolished as a separate independent executive agency. The Community Services Administration provided a variety of services to low-income elderly through a national network of community action agencies. Its legislation specifically authorized the senior opportunities and services (SOS) program which was subsequently eliminated by Public Law 97–35. (Authority for the continuation of the SOS program under the Older Americans Act was included as part of that act's reauthorization in 1981.)

The Reconciliation Act authorized the CSBG through fiscal year 1986, at an annual level of $389.5 million, and included a 26-percent reduction in the fiscal year 1982 authorization level as compared to fiscal year 1981. The program is administered by a newly created Office of Community Services (OCS) within the Department of HHS. The Secretary may reserve up to 9 percent of appropriations each year for discretionary use. During fiscal year 1982, States could choose not to administer the block grant, in which case HHS would continue programs which had been funded by CSA in fiscal year 1981 in those States. Further, during fiscal year 1982, States were required to use at least 90 percent of their allotment for community action agencies and related programs funded in fiscal year 1981 by CSA.

D. Volunteer Programs [20]

OLDER AMERICAN VOLUNTEER PROGRAM

The older American volunteer program (OAVP), authorized under title II of the Domestic Volunteer Services Act, and administered by ACTION, includes the retired senior volunteer program (RSVP), the foster grandparent program (FGP), and the senior companion program (SCP). The RSVP provides volunteer opportunities for

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[19] For further information see CRS Archived Mini Brief No. 82211, "Social and Community Services Block Grants: FY83 Budget Issues," by Karen Spar, and Archived Mini Brief, "Community Services Administration: Conversion to Block Grant," by Karen Spar.

[20] For further information, see CRS Typed Report, "Domestic Volunteer Service Programs under ACTION," by Social Services Section, Education and Public Welfare Division, Dec. 27, 1982.

persons 60 years and over in community settings; the FGP provides volunteer opportunities for low-income persons 60 years and over who render supportive services to children with physical, mental, emotional, and social disabilities; and the SCP provides volunteer opportunities for low-income persons 60 years of age who render supportive services to homebound or institutionalized persons. Both foster grandparents and senior companions serve 20 hours a week and receive a stipend of $2 an hour.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) reauthorized the OAVP through fiscal year 1983. The law also amended section 211 of the act to create a separate part C which now contains the authorization for the senior companion program. The law provided for the following fiscal year 1982 authorization levels: For RSVP, $28.691 million; for FGP, $49.67 million; and for SCP, $16.6 million. These levels were lower than those previously authorized for fiscal year 1981, and total appropriations for these programs decreased from $88.9 million in fiscal year 1981 to $84.637 million in fiscal year 1982. The fiscal year 1983 authorization levels included in the law are: For RSVP, $30.412 million; for FGP, $52.65 million; and for SCP, $17.607 million. Total fiscal year 1983 appropriations for the three programs are $87.861 million.

E. Legal Services

LEGAL SERVICES CORPORATION [21]

The Federal Government has administered a program of legal services for the poor since 1966, originally through the Office of Economic Opportunity and currently through the private, nonprofit Legal Services Corporation (LSC). Legislation creating the LSC was enacted in 1974, and the Corporation is headed by an 11-member board of directors nominated by the President and confirmed by the Senate. The Corporation does not provide legal services directly but instead funds local legal aid projects. The Corporation has 326 local grantees that provide legal services through 1,187 neighborhood offices in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Micronesia. These local projects employ more than 4,500 attorneys and 1,800 paralegals.

The Legal Services Corporation Act of 1974 was reauthorized in 1977 for 3 additional years through fiscal year 1980. The 96th and 97th Congresses approved legislation to continue the LSC under a series of continuing appropriations measures which have served as both authorizing and funding legislation. Public Law 96–536 and Public Law 97–12 contained funds for the LSC and served as the authorizations for the program in fiscal year 1981, and Public Law 97–161 contained an authorization for fiscal year 1982. The program is currently authorized and funded through September 30, 1983, by Public Law 97–377. This measure contains a fiscal year 1983 continuing appropriations of $241 million, the same amount as in fiscal year 1982. This level is a decrease from the fiscal year 1981 level of $321.3 million.

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[21] For further information, see CRS Issue Brief No. 81071, "Legal Services Corporation: Proposed Termination," by Karen Spar.

F. Employment

1. Community Service Employment Program for Older Americans [22]

The community service employment program, title V of the Older Americans Act, has as its purpose to subsidize part-time employment in community service activities for low-income persons age 55 and over. Modeled after a program originally authorized under the Economic Opportunity Act, it became part of the Older Americans Act in 1973, and is administered by the Department of Labor (DOL). Participants work in a wide variety of community service activities, with about half the jobs situated in service programs for the elderly. Enrollees are paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is higher. In carrying out the program, DOL awards funds to State agencies on aging and national organizations.

The program was the subject of legislative and appropriations action during the 97th Congress. The Older Americans Act Amendments of 1981 (Public Law 97–115, enacted December 29, 1981) provided a 3-year reauthorization of the program through fiscal year 1984 and included a number of amendments. Prior law provisions that those eligible for community service employment have poor employment prospects and have difficulty in obtaining employment were deleted. The law added a new provision emphasizing transition of participants into unsubsidized employment. This provision requires the Secretary of Labor to use at least 1, but no more than 3 percent of title V funds exceeding the 1978 level of appropriations, to conduct experimental projects designed to assure second career transition and placement of participants with private business concerns. The law also required that a portion of funds in excess of the fiscal year 1978 level of appropriations be awarded specifically to State agencies on aging. It required that funds for the program be expended on a "forward funded" basis, that is, funds appropriated by Congress for any fiscal year are to be expended, beginning in July of that fiscal year through June 30 of the following year, rather than on a Federal fiscal year basis.

Congress reaffirmed its support for the program through a number of continuing and supplemental appropriations measures passed during the 97th Congress. A continuing resolution for fiscal year 1982 had provided $66.528 million for only the last quarter of fiscal year 1982 (July–September 1982). Because the program is "forward funded" supplemental appropriations for fiscal year 1982 were needed to continue the program for the period October 1982 through June 1983. While various supplemental approriations bills contained additional amounts to support the program beyond September 1982, as well as funds for other Federal programs, they were vetoed by the President. In September 1982, Congress overrode a veto of another supplemental appropriations bill. This veto override, enacted as Public Law 97–257, assured continuation of the program at a level of

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[22] For further information, see CRS Archived Issue Brief No. 82016, "Older Americans Act—Elimination of the Community Service Employment Program and Other FY83 Budget Proposals," by Carol O'Shaughnessy.

$277.1 million through June 1983. In action on the fiscal year 1983 budget Congress has also assured continuation of the program for the program year 1983–84; appropriations for that year are $281.950 million.

2. JOB TRAINING PARTNERSHIP ACT [23]

The Job Training Partnership Act (Public Law 97–300, enacted October 13, 1982) is a replacement for the Comprehensive Employment and Training Act (CETA). Under this program each State will receive a formula allocation to be used for statewide training programs which are developed within local service delivery areas approved by the Governor. Local job training programs will be developed jointly by a private industry council (PIC), a majority of whom are private sector representatives, and the chief elected officials in the service delivery area. The role of the PIC is to provide policy guidance, oversee local job training programs, establish procedures for developing a job training plan, and select a recipient of funds to carry out the training program.

Title II–A, which authorizes training for disadvantaged adults and youth, requires that 70 percent of program funds be directed toward training activities, with the remainder used for administration and other expenses, such as supportive services (e.g., transportation costs of trainees), work experience costs, and needs-based payments to trainees.

Under title II Congress included a special funds set-aside for older workers. This provision requires each Governor to spend 3 percent of the funds allotted to the State for training programs, specifically for economically disadvantaged persons 55 years or older (including persons with income no higher than the Office of Management and Budget poverty level, or 70 percent of the Bureau of Labor Statistics lower living standard level). In implementing this provision, the Governor is required to enter into agreements with public agencies, nonprofit private organizations, and private business, and to give consideration to training for jobs in growth industries and jobs reflecting the use of new technological skills. In addition to this special funds set-aside for older workers, up to 10 percent of title II participants may include persons who are not "disadvantaged" (including older workers).

G. Housing [24]

1. SECTION 8

The section 8 program of the Department of Housing and Urban Development (HUD) provides assistance to the low-income elderly in the form of assistance for rental payments. Three-tenths of the existing section 8 units and two-thirds of the completed new construction units are designated for the elderly and handicapped.

Until recently, tenants living in section 8 housing were required to pay up to 25 percent of their incomes for rent. The Housing and Com-

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[23] For further information, see CRS Issue Brief No. 82005, "Job Training Programs: Reauthorization and Funding Issues," by Karen Spar.

[24] For further information, see CRS report No. 82–119E, "Housing Programs Affecting the Elderly: A History and Alternatives for the Future," by Susan Vanhorenbeck.

munity Development Amendments of 1981 (included in the Omnibus Budget Reconciliation Act of 1981, Public Law 97–35) increased this to 30 percent. The law also called for the use of existing housing rather than the construction of new section 8 projects.

In an attempt to make more units available to the more needy, this law also limited occupancy of lower income families to 10 percent and targeted the remainder of the units to very low-income families. Those with income under 50 percent of the area median income, adjusted for household size, are called very low income, while those below 80 percent of median are lower income.

The Housing and Urban Development Independent Agencies Appropriations Act for FY 1983 (Public Law 97–272, enacted September 30, 1982) does not appropriate any funds for annual contributions, contract authority, or budget authority for section 8 pending adoption of an authorization bill. The authorization bill (H.R. 6296), which would have authorized $840 million in annual contract authority and $16 billion in budget authority for public housing and section 8 in 1983, died without final action by Congress. In its place, Congress has approved assisted housing appropriations for 1983 as part of Public Law 97–377, fiscal year 1983 continuing appropriations (enacted December 21, 1982). The law will fund approximately 65,000 rent supplement section 8 conversion units. In addition, 67,148 section 8 existing units and 15,000 section 8 moderately rehabilitated units are funded from the anticipated recapture of $4.6 billion, such as through repayment of loans, in 1983.

2. PUBLIC HOUSING

The public housing program is the oldest and most extensive program providing housing for the elderly. At the end of fiscal year 1981 about 45 percent of all public housing units were occupied by the elderly.

The Housing and Community Development Amendments of 1981 (Public Law 97–35) changed the income requirements to make them the same as in the revised section 8 program, and raised the occupants' rent payments to 30 percent of adjusted income, with the increase to be phased in over a 5-year period.

Public Law 97–377, the fiscal year 1983 continuing appropriations, provided $2.5 billion of new authority for public housing modernizations, enough to modernize approximately 100,000 units. No new funds were provided for new construction or substantial rehabilitation of low-rent public housing projects because Congress feels that the $9 billion in the existing public housing pipeline is sufficient.

3. SECTION 202

Section 202 provides construction and permanent financing loans for the development of housing for the elderly and handicapped. The HUD appropriation for fiscal year 1983 (Public Law 97–272, enacted September 30, 1982) projects reservations for 10,000 new and substantially rehabilitated section 202 units through an appropriation of $453 million.

In an attempt to cut the cost of housing subsidies and enable more people to receive aid from limited funds, the 1983 budget encourages the use of existing buildings rather than new construction. The only funding available for the construction of subsidized housing in fiscal year 1983 is for the 14,000 units of section 202 housing as provided for by Public Law 97–377, fiscal year 1983 continuing appropriations.

4. CONGREGATE HOUSING SERVICES

In 1978, the Congregate Housing Services Act authorized HUD to award grants to public housing authorities and section 202 housing sponsors to provide nutritional meals and supportive services to partially impaired elderly and handicapped persons, allowing them to remain in their own dwellings rather than be institutionalized. Program participants are required to pay a fee, based on their ability to pay, for the services received.

$10 million was appropriated for the congregate services program in fiscal years 1979, 1980, and 1981. HUD's appropriation bill for fiscal year 1983 provides $4 million for the program, with $3.5 million targeted to fund projects now in operation, and the other $0.5 million for the development of new projects in rural areas.

H. TAXATION

The Federal tax structure has been changed by two major income tax laws—the Economic Recovery Tax Act of 1981 (Public Law 97–34) and the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248). These laws included a number of provisions which have particular interest to elderly taxpapers.

Selected provisions of Public Law 97–34 are the following:

Exclusion of capital gain from sale of principal residence for persons age 55 and over.—The law increased the one-time exclusion of gain that is available to individuals who are 55 years of age or older upon the sale of their principal residences. In the case of sales and exchanges of a principal residence after July 20, 1981, the maximum exclusion amount increases from $100,000 ($50,000 for married persons filing separate returns) to $125,000 ($62,500 for married persons filing separate returns).

Dependent care tax credit for noninstitutional services.—Beginning in 1982, a taxpayer who maintains a household for a dependent or spouse who is physically or mentally disabled may claim a tax credit for employment-related expenses. Employment-related expenses include expenses for household services and expenses for the care of the disabled dependent or spouse which are incurred in order to permit the taxpayer to be gainfully employed. Expenditures made for out-of-home noninstitutional care, where the dependent spends at least 8 hours a day in the taxpayer's home, are eligible for the credit. Dependent care centers must be in compliance with all State and local regulations for the taxpayer to count such expenditures toward qualified expenses. Under prior law, services outside the home qualified only if they involved the care of a child under 15 years of age.

Under the new law, taxpayers may claim a nonrefundable credit of 30 percent of qualified expenses if their adjusted gross income is $10,000 or less. For taxpayers with incomes above $10,000 the credit is reduced by 1 percent for each additional $2,000 of adjusted gross income until an adjusted gross income of $28,000 is reached. Taxpayers with adjusted gross incomes in excess of $28,000 are provided a minimum 20-percent credit toward qualifying expenditures. The maximum amount of qualifying expenses is $2,400 for one dependent or $4,800 for two or more dependents.

Exclusions of income as gifts.—Beginning in January 1982, the new law increased from $3,000 to $10,000 the value of gifts to any one person, per year, which can be made tax free. The value for a gift split between husband and wife was increased from $6,000 to $20,000. The new law also exempted from the gift tax certain gifts made to pay for medical expenses. In this case, the donor must pay the gift directly to the persons providing the medical care.

The new law also required that the gift tax return be filed on an annual basis, rather than on the quarterly basis required in some cases under prior law.

Declaration and payment of estimated taxes.—Elderly individuals often must file and pay estimated tax payments since they often receive a large portion of their income from sources not subject to Federal tax withholding such as rental income. The law relaxed the requirements regarding declaration and payment of estimated taxes by individuals.

In 1982 the tax liability threshold was increased from $100 to $200 and will continue to increase at the rate of $100 per year until 1985. Thus, individuals with tax liability under the threshold amount will not need to file and pay estimated tax payments. The threshold amounts by year are as follows:

	Threshold amount
1981	$100
1982	200
1983	300
1984	400
1985 and thereafter	500

Selected provisions contained in Public Law 97–248 are the following:

Medical expense deduction.—The floor for deductible medical expenses was increased from 3 to 5 percent of adjusted gross income. The deduction for one-half (up to $150) of medical insurance premium expense was repealed. These two changes were made for tax years beginning in 1983.

As of 1984, the separate 1-percent adjusted gross income floor for drug expenditures will be removed. At that time, only prescription drugs and insulin will qualify as drug expenditures for use with the medical expense deduction.

Withholding on interest and dividend income.—As a result of Public Law 97–248 payors of interest, dividends, or patronage dividends to individuals are now required to withhold and pay to the Federal Government amounts liable for taxes beginning in 1983. A withholding rate of 10 percent has been established for interest or dividend income credited after June 30, 1983. The law

requires that amounts are to be withheld when credited to the payee's account. The payor may elect not to withhold if the aggregate interest payments for the year will not exceed $150.

Individuals whose tax liability for the preceding year was less than $600 (if single) or $1,000 (if married), and individuals over age 65 whose tax liability was less than $1,500 (if single) or $2,500 (if married) may elect not to have payments withheld from their interest and dividends. In the case of a married taxpayer only one of the individuals must meet the over age 65 requirement. To qualify for this exemption a certificate must be filed with the payor of the interest/dividend income.

Withholding on pensions, annuities, and deferred income.—Beginning in 1983, Federal income tax will be withheld from the taxable portion of pension payments, annuities, and other deferred income arrangements unless the taxpayer specifically asks not to have income tax withheld. Those persons subject to withholding may elect not to participate in this system for any reason. Nonperiodic payments are subject to a flat 10-percent rate.

Payors are required to notify annually all recipients of their rights to make, renew, or revoke an election concerning withholding.

I. Transportation

1. URBAN MASS TRANSPORTATION ACT

Section 16(b)(2) of the Urban Mass Transportation Act of 1964, as amended, allows a set aside of urban discretionary grant funding for capital assistance grants to States, local agencies, and private nonprofit groups for transit services to the elderly and handicapped.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) authorized $36 million for fiscal year 1982 for the section 16(b)(2) transit services for the elderly and handicapped, which was an increase of $6 million over the fiscal year 1981 authorized amount of $30 million.

In addition, the Federal Public Transportation Act of 1982 (title III of the Surface Transportation Assistance Act of 1982, Public Law 97–424, signed January 6, 1983) authorized funds for this program through fiscal year 1986. This law also increased the proportion of total urban discretionary grants allowed to be set aside for the elderly and the handicapped from 2 to 3.5 percent. The law directed the Secretary of Transportation to promulgate final regulations regarding transportation services for the elderly and the handicapped within 180 days of enactment.

2. BUS REGULATORY REFORM

The Bus Regulatory Reform Act of 1982 (Public Law 97–261, enacted September 20, 1982) provided the bus industry with increased flexibility in the operation of bus routes and eliminated almost all Federal regulation of the passenger broker industry. The law is expected to increase competition within the industry by allowing bus companies to enter new markets and to drop services to unprofitable ones. This law may affect the elderly, who may be more frequent riders, by changing current bus operating patterns.

J. Crime and Victim Protection

The Omnibus Victims Protection Act of 1982 (Public Law 97–291, enacted October 12, 1982) amended a number of Federal laws govering criminal offenses by establishing new, and strengthening existing, protections for victims and witnesses of crime. The law amended the Federal Rules of Criminal Procedure to require that presentence reports, documents used by judges in sentencing defendants, contain information assessing the impact of the crime on the victim and the cost of the crime. It also authorized a sentencing court to order the defendant to make restitution for any offenses and required the court to state, for the record, the reasons for not ordering such restitution. Restitution may include coverage of uninsured medical expenses, property losses, and funeral and burial expenses. The law also amended the Federal criminal code by establishing as a crime the harassment of a witness, victim, or informant.

In addition, the law required the Attorney General to develop guidelines for fair treatment of crime victims and witnesses in the criminal justice system. The Attorney General is directed to consider certain objectives in preparing these guidelines, including insuring that victims receive prompt social and medical services, giving witnesses notice of important criminal justice proceedings, and encouraging employers to continue to pay victims and witnesses for work absences to assist investigations and prosecutions.

Part 3

SELECTED LEGISLATION PROPOSED IN THE 97TH CONGRESS, NOT ENACTED

This section presents selected legislative proposals affecting the elderly considered, but not enacted, during the 97th Congress. It contains only a few selected bills, chosen to exemplify areas of interest to the elderly during the 97th Congress and to present subject areas which may receive attention by the 98th Congress. Because of the high number of bills affecting programs for older persons, this selection of bills is somewhat arbitrary.

A brief description of each bill and action on it during the 97th Congress are included. Some bills received no action while hearings were held on others. The bill is followed by the name of the member who introduced the bill. Cosponsors are not listed.

A. Age Discrimination in Employment/Employment Services

1. H.R. 6576 (PEPPER ET AL.)/S. 2617 (HEINZ ET AL.)

Prohibition of Mandatory Retirement and Employment (ADEA) Rights Act of 1982. Would amend the Age Discrimination in Employment Act to remove the upper age limit of 70 years for mandatory retirement, hiring, and promotions.

Status: H.R. 6576 introduced June 10, 1982; referred to the Committee on Education and Labor; hearings held September 9, 1982. S. 2617 introduced June 10, 1982; referred to the Committee on Labor and Human Resources; hearings held August 18, 1982.

2. S. 2844 (QUAYLE)

Age Discrimination in Employment Amendments of 1982. Would amend the Age Discrimination in Employment Act to remove the upper age limit of 70 years for mandatory retirement, hiring, and promotions; would eliminate jury trials and liquidated damages under the ADEA; would reinstate an exception for tenured faculty.

Status: Introduced August 16, 1982; referred to the Committee on Labor and Human Resources.

3. H.R. 7256 (BIAGGI)

Would provide that the community service employment program for older Americans (title V of the Older Americans Act), currently administered by the Department of Labor, be transferred to the administrative jurisdiction of the Commissioner of the Administration on Aging within the Department of Health and Human Services. Also

would transfer the older American volunteer programs from ACTION to the jurisdiction of the Commissioner.

Status: Introduced October 1, 1982; referred to the Committee on Education and Labor.

B. Community-Based Long-Term Care Services

1. S. 861 (PACKWOOD)/H.R. 3355 (FENWICK)

Noninstitutional Acute and Long Term Care Services for the Elderly and the Disabled Act. Would add a new title XXI to the Social Security Act providing for a 10-State, 6-year demonstration program of comprehensive community-based noninstitutional acute and long-term care services for the elderly and disabled. Would provide that all noninstitutional acute and long-term care services presently available under medicare, medicaid, and the title XX social services program be combined under the new title XXI. Would make a preadmission screening assessment team (PAT) responsible for conducting an assessment of each person seeking title XXI services and developing a plan of care for each person.

Status: Introduced April 2, 1981; referred to Committee on Finance. H.R. 3355 introduced April 30, 1981; referred to Committees on Energy and Commerce and Ways and Means.

2. S. 234 (HATCH)/H.R. 2414 (MOLINARI)

Community Home Health Service Act of 1981. Would amend the Public Health Service Act to provide assistance through grants and loans for development and expansion of home health agencies and for training home health personnel. (A similar provision was actually enacted by Public Law 97–414, see section on "Home Health Services" in part 2). Would also amend title XVIII of the Social Security Act (medicare) to provide that homebound persons needing homemaker-home health aide services (not otherwise available through family or community resources on a more cost-effective basis), or occupational or respiratory therapy, could qualify for medicare home health benefits, but only if such individuals would otherwise require institutionalization.. Would amend the Internal Revenue Code to create a new tax credit of up to $500 for households with certain disabled dependents.

Status: S. 234 introduced January 22, 1981; referred to Committee on Labor and Human Resources; hearings were held March 4 and November 10, 1981. Reported (as amended) on December 15, 1981 (S. Rept. 97–325). H.R. 2414 introduced March 10, 1981; referred to Committees on Energy and Commerce and on Ways and Means.

3. H.R. 6145 (CONABLE)

Medicare Long Term Care Act of 1982. Would amend title XVIII (medicare) of the Social Security Act to establish a voluntary program to provide long-term care benefits for aged and disabled individuals who elect to enroll under such program, financed from premium payments by enrollees, together with contributions from funds

appropriated by the Federal Government and contributions by States. Would provide for the creation of community long-term care centers and State long-term care agencies as part of a new administrative structure for the organization and delivery of long-term care services, and provide a significant role for persons eligible for long-term care benefits in the administration of the program.

Status: Introduced April 22, 1982; referred to Committees on Energy and Commerce and Ways and Means.

C. Income

1. H.R. 3396 (PEPPER ET AL.)

Retirement Security Portability Non-Discrimination (RESPOND) Act of 1981. Would require that all employers provide a minimum pension benefit equivalent to 4 percent of wages subject to social security payroll tax. Would provide tax credits in addition to currently allowable deductions for employer contributions to qualified plans. Also would provide for establishment and operation of special master and prototype plans, vesting after 5-years' service, additional benefit accruals for service performed after normal retirement age, improved reciprocity arrangements among collectively bargained pension plans to facilitate portability, a joint and survivors annuity requirement in the case of the death of a plan participant, and a cap on the degree to which plans may integrate benefits with social security.

Status: Introduced May 1, 1981; referred jointly to Committees on Education and Labor, and Ways and Means.

2. H.R. 4928 (ERLENBORN ET AL.)/S. 2105 (CHAFEE)

Public Employee Pension Plan Reporting and Accountability Act of 1982. Would establish reporting and disclosure requirements for State and local government pension plans, including legal standards for managing and investing fund assets. Specifically, the legislation would require disclosure and reporting to participants and their beneficiaries, State and local taxpayers, employers, employee organizations, and the general public, of financial and other information about such plans, and for other purposes.

Status: Introduced November 10, 1981; referred jointly to Committee on Education and Labor, and Ways and Means. Reported by Education and Labor Committee May 17, 1982 (H. Rept. 97–529, part 1).

3. H.R. 4929 (BURTON, P., ET AL.)/S. 2106 (CHAFEE)

Public Employee Pension Plan Reporting and Accountability Act of 1982. Identical to H.R. 4928 with the exception that H.R. 4929 omits amendments to the Internal Revenue Code.

Status: Introduced November 10, 1981; referred jointly to Committees on Education and Labor, and Ways and Means. Hearings held February 3, 1982. Reported by Education and Labor Committee May 17, 1982 (H. Rept. 97–528).

4. S. 2905 (STEVENS)

Civil Service Reform Act of 1982. Would completely restructure the civil service retirement system by covering new Federal employees by social security, establishing a fully-paid-by-employer "defined contribution" pension, and adding a voluntary "thrift plan" with matching Government contributions. Would also replace the present sick-leave disability configuration with a new one providing for distinctions between short- and long-term disability. Would provide that all new employees would be brought in under the new system and incentives for voluntarily joining are provided to current workers.

Status: Introduced September 14, 1982. Referred to Committee on Governmental Affairs.

5. S. 484 (CHILES)

Social Security Reform Act of 1981. Would improve the short- and long-term solvency of social security through the following changes: (1) Eliminate minimum benefit for new retirees; (2) phase out college student benefits for new beneficiaries; (3) authorize interfund borrowing between the trust funds; (4) gradually raise the retirement age between the years 2000 and 2012 to age 68 for full benefits and age 65 for early retirement reduced benefits; (5) promote opportunities for older workers by eliminating the earnings limitation, eliminating mandatory retirement by removing age 70 as the permissible age for forced retirement, and waiving the social security payroll tax for employees over age 65 and their employers.

Status: Introduced February 17, 1981. Hearings held by Ways and Means Committee and Senate Finance Committee. First three portions of bill (see above) incorporated into Public Law 97–35 and Public Law 97–123.

D. Taxation

S. 2424 (HEINZ)

Would amend the Internal Revenue Code of 1954 to allow a credit against tax for expenses incurred in the care of elderly family members.

Status: Introduced April 22, 1982. Referred to the Senate Committee on Finance. Hearings held on May 21, 1982.

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98th Congress
1st Session

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PROSPECTS FOR MEDICARE'S HOSPITAL INSURANCE TRUST FUND

AN INFORMATION PAPER

PREPARED FOR USE BY THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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This document has been printed for information purposes. It does not offer findings or recommendations by this committee

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PREFACE

The financial health of the medicare program is an urgent concern for those interested in the continued access to health care and protection from ruinous medical expenses that medicare helps provide. No other program so widely serves older Americans. Over 95 percent of individuals 65 and over are covered by medicare, and the program paid an average of 45 percent of those persons' annual health care bills in 1980.

This staff information print was prepared at the request of the committee by the Congressional Budget Office. It projects, for the first time in a Government report, the magnitude of the changes that will be necessary to maintain the HI trust fund if increases in hospital costs continue to substantially outpace the overall rate of inflation.

According to the projections in this study, we have at most until the end of the decade to remedy the growing disparity between the costs of health care and the revenues committed to pay for it. Although the projections are indeed sobering, the challenge is clear: Health policymakers, the Congress, and the American public must begin to face the need for health care financing reform, and we have relatively little time in which to do so successfully. This report is a first step to that end.

JOHN HEINZ,
Chairman.
JOHN GLENN,
Ranking Minority Member.

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PROSPECTS FOR MEDICARE'S HOSPITAL INSURANCE TRUST FUND

A. INTRODUCTION

Medicare is comprised of two programs—hospital insurance (HI), which pays for inpatient hospital care, stays in skilled nursing facilities, and home health services, and supplementary medical insurance (SMI), which pays for all other services covered by medicare, principally physician services. The programs are financed through separate trust funds, with distinct sources of revenues.

Revenues for HI come almost exclusively from a portion of the social security payroll tax. Employers and employees covered by the program each contribute 1.3 percent of earnings up to a maximum of $35,700, and the rate is scheduled to increase to 1.35 percent in 1985, and 1.45 percent in 1986.[1] Under current law, general revenues cannot be used to make up any shortfall between outlays required to pay benefits and trust fund balances.

In contrast, SMI revenues are obtained from both premiums and general revenues. The premium amount ($12.20 per month now, and $13.50 per month after July 1, 1983) is set by law, with a contribution from general revenues making up the difference between premium income and outlays. In 1983, general revenues required to meet SMI outlays will total $14.2 billion, or 74 percent of SMI funding.

Projections of outlays and income for the HI trust fund indicate serious financing problems later in this decade. Continued solvency of this program through 1995 will require either outlay reductions that are much larger than any program options currently under discussion, or very substantial increases in revenues. Projections of growth in SMI outlays are also alarming. Though the solvency of SMI is not at issue because of the program's ability to tap general revenues, the appropriation required by 1988 is expected to amount to $31.9 billion a year.

This memorandum presents projections of the HI trust fund through 1995 and explains the factors causing the imbalance between income and outlays. It then illustrates the magnitude of the imbalance by estimating the degree of outlay reduction and tax increase options required to avoid depletion of the trust fund. All of the numbers that follow are for calendar years.

B. PROJECTIONS OF HI TRUST FUND BALANCES

Balances in the HI trust fund are projected to be exhausted during 1987. Though the HI balance was a substantial $18.7 billion at the end of 1981, borrowing by the old-age and survivors insur-

[1] The maximum increases each year in accordance with the increase in average wages.

ance (OASI) trust fund reduced the HI balance to $8.3 billion at the end of 1982 (see table 1 and figure 1). This already low balance is projected to decline slowly through 1986 and rapidly in ensuing years, as outlays exceed income by a widening margin.[2] Annual program deficits—that is, the excess of a year's outlays over that same year's income--will reach $8.6 billion in 1987, when the balance is exhausted, and they will increase to $24.2 billion in 1990 and to $73.8 billion in 1995 (see figure 2).[3] Though CBO's projection period ends in 1995, deficits under current law are likely to continue to grow thereafter.

TABLE 1.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES

[In billions of dollars]

Calendar year	Outlays	Income [1]	Annual surplus [2]	Yearend balance
1981	$30.7	$35.7	$5.0	$18.7
1982	36.0	25.6	−10.4	8.3
1983	41.1	41.6	−0.5	8.8
1984	46.2	44.8	−1.4	7.5
1985	51.0	49.5	−1.5	5.9
1986	60.0	56.3	−3.7	2.2
1987	68.5	59.7	−8.6	−6.5
1988	77.0	63.1	−12.9	−20.4
1989	86.6	66.3	−18.1	−40.7
1990	97.4	69.2	−24.2	−68.9
1991	109.5	71.7	−31.6	−106.7
1992	123.0	73.5	−40.0	−156.3
1993	138.2	74.7	−49.7	−219.8
1994	155.4	75.1	−60.9	−300.1
1995	174.8	74.1	−73.8	−400.9

[1] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. In years when balances are negative, income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowings required to continue benefit payments. Income in 1982 reflects $12.4 billion in interfund transfers from the HI trust fund to the OASI trust fund.

[2] Excluding any negative interest.

Note.—Minus signs denote deficits.

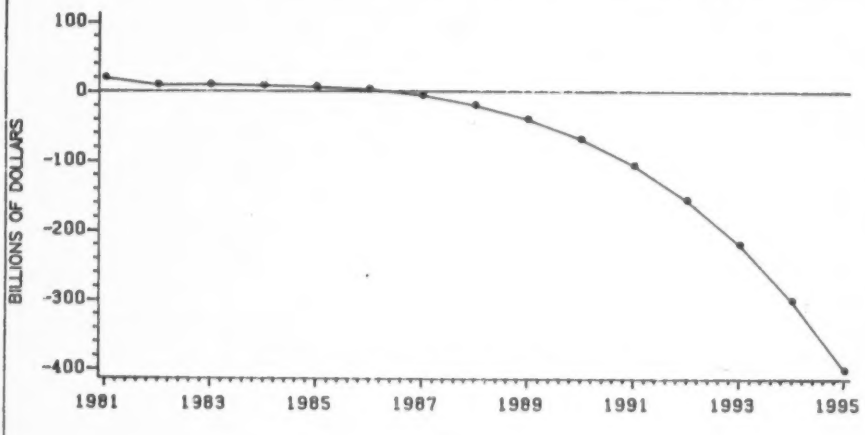
Source: Preliminary CBO estimates.

[2] These estimates assume that no additional interfund borrowing by the old-age and survivors insurance trust fund (OASI) (beyond the $12.4 billion conducted through December 31, 1982) will occur, but that past borrowing will not be repaid. Any additional interfund borrowing from HI to OASI that is not repaid by 1987 would hasten the depletion of balances, whereas repayment of the entire borrowing by that date would delay depletion only until 1988.

[3] These estimates of annual deficits exclude negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowings after 1986 required to continue benefit payments.

FIGURE 1

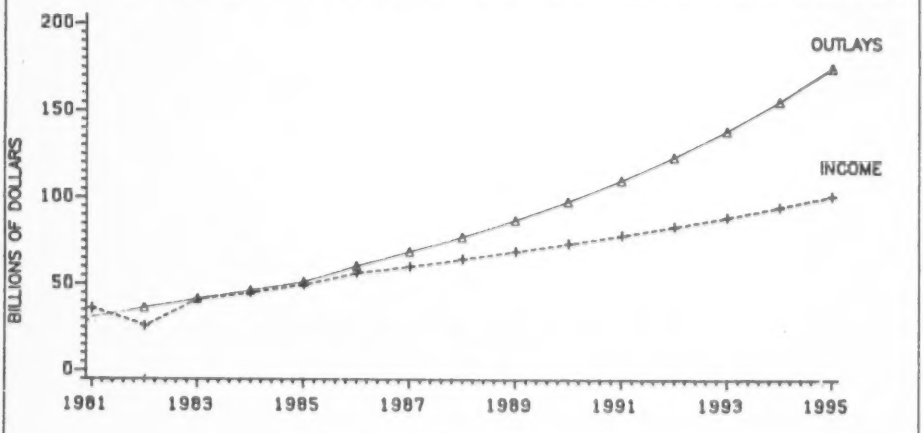
H.I. TRUST FUND BALANCES



NOTES: SEE TABLE 1

FIGURE 2

H.I. TRUST FUND INCOME AND OUTLAYS



NOTES: SEE TABLE 1

These projections assume that hospital reimbursement growth rate limits enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) will not be extended past their scheduled expiration in 1985 and 1986. The committee report indicated, however, that these growth rate limits were interim steps in the direction of adopting a prospective reimbursement system.[4] Future legislation might replace these growth rate limits with other reimbursement changes that would reduce outlays past 1986 as well.

If the TEFRA restrictions were extended so that percentage reductions in reimbursements achieved by the third year—approximately 9 percent below prior law—were continued, depletion of the HI balance would be delayed, but only by 1 year (see table 2). By 1988, the HI trust fund would still be exhausted, with the cumulative negative balance reaching $310 billion by 1995.

TABLE 2.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND BALANCES IF TEFRA REIMBURSEMENT LIMITS ARE EXTENDED

[In billions of dollars]

Calendar year	Outlays [1]	Income [2]	Annual surplus [3]	Yearend balance
1985	$50.9	$49.5	$−1.4	$6.0
1986	57.1	56.4	−0.6	5.4
1987	64.3	60.3	−4.0	1.4
1988	72.3	63.9	−8.2	−7.0
1989	81.3	67.5	−12.8	−20.8
1990	91.5	70.9	−18.3	−41.4
1991	102.9	74.0	−24.9	−70.3
1992	115.6	76.5	−32.5	−109.3
1993	129.9	78.6	−41.3	−160.5
1994	146.0	80.1	−51.4	−226.5
1995	164.2	80.4	−63.2	−310.3

[1] Assumes extension of TEFRA growth rate limits past their scheduled expiration in 1985 and 1986, so that the third-year percentage reductions in reimbursements below prior law (about 9 percent) are continued.

[2] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. In years when balances are negative, income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowings required to continue benefit payments. Income in 1982 reflects $12.4 billion in interfund transfers from the HI trust fund to the OASI trust fund.

[3] Excluding any negative interest.

Note.—Minus signs denotes a deficit.

Source: Preliminary CBO estimates.

The HI financing problems stem from the fact that outlays are affected by hospital costs that are growing much more rapidly than the earnings to which the HI tax is applied. Hospital costs attributable to medicare beneficiaries are projected to increase over the 1982–95 period at an average annual rate of 13.2 percent, while covered earnings are projected to grow at an annual rate of only 6.8 percent.[5] With a difference of 6 percentage points per year between the key determinants of HI outlays and income, serious financing problems seem inevitable.

[4] See Tax Equity and Fiscal Responsibility Act of 1982, H. Rept. 97-760, 97th Cong., 2d Sess. (1982).

[5] The projection of hospital costs has three major components: Prices paid by hospitals for labor, capital, and supplies; the resources used per medicare enrollee; and the number of medicare enrollees. The first component is estimated in a straightforward manner from CBO economic assumptions. The second is based on an extrapolation of trends over the last 10 years. The third is based on population projections of the Social Security Administration.

This estimate abstracts from any reductions in hospital costs induced by the reimbursement provisions in TEFRA, focusing only on the underlying cost increases.

1. Outlays

The projected growth in hospital reimbursements is attributable primarily to rising hospital costs, and to a lesser extent, to the aging of the population. Rising hospital costs account for 10.8 percentage points of the 13.2 percent annual projected growth in hospital costs attributable to medicare beneficiaries; aging of the population accounts for 2.2 percentage points.

General inflation is projected to account for a significant portion of the increase in hospital costs. Over the 1982–95 period, an index of hospital input price increases—that is, the prices paid by hospitals for labor, capital goods, and supplies—is projected to increase at an average rate of 6 percent a year. General inflation is not a particular problem for the HI trust fund, however, because it is also reflected in the earnings that are taxed to provide income to the fund.

Another important component of rising costs—roughly 4.4 percentage points per year—reflects changes in practice of medical care affecting the elderly. This includes both a higher hospital admission rate for the elderly and more resources applied per hospital stay. New procedures are continually entering mainstream medical care, and many of them are expensive. For example, coronary artery bypass surgery, experimental in 1970, is now a common procedure. Medicare reimbursements for hospital care alone (excluding surgeons' and anesthesiologists' fees) for this procedure exceeded $15,000 per case in Maryland in 1980, and will probably reach $20,000 in 1983.[6]

Some expensive new procedures have questionable medical effectiveness, let alone cost-effectiveness, however. Examples of new procedures whose effectiveness in certain applications has been questioned by some, include therapeutic plasmapheresis, radial keratotomy, and a number of imaging procedures in cardiology, such as nuclear magnetic resonance, ultrasound, radionuclide scanning, and digital subtraction angiography.

Although aging of the population also accounts for some of the increase in HI outlays, the contribution of this factor is somewhat smaller than is commonly believed. The number of persons aged 65 and over is expected to grow by 2 percent a year over the 1982–95 period,[7] and the average age of the elderly population is also expected to increase. HI reimbursements increase with age, with beneficiaries aged 85 and older accounting for almost double the reimbursements per enrollee of those aged 65 to 69.[8] Nevertheless, the aging of the elderly population is a slow process, and it explains only 0.2 percent per year of reimbursement growth. Combining the growth in enrollment by the elderly with the cost implications of the aging of this population accounts for reimbursement growth of 2.2 percent a year.

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[6] See Harold Cohen, Margaret Skolnick, and Arlene Stephenson, "The Financing of Coronary Artery Bypass Surgery," Circulation, vol. 66, No. 5 (November 1982), pp. III-49 to III-55.

[7] Calculated from the "1981 Social Security Trustees Report, Alternative II."

[8] See Health Care Financing Administration, "Medicare Summary: Use and Reimbursement by Person, 1976–1978" (August 1982).

2. Income

Turning to the income side of the HI problem, the projection of an average 6.8 percent growth rate in earnings that are subject to the HI payroll tax reflects a forecast of the near-term performance of the economy and assumptions of moderate growth thereafter. Though the estimates for 1983 and 1984 were developed using the most recent CBO economic forecast, which reflects the current recession, those for later years assume moderate noncyclical growth with gradually declining inflation. Whether the projected growth path is attainable with tax and spending policies now in place is uncertain, however.[9]

Though the current recession is reducing income to the HI trust fund, it does not account for the long-term financing problem. Unemployment reduces HI income by diminishing the earnings pool that is taxed. Each 1 percent increase in the unemployment rate reduces HI income by about $1 billion in 1984, or 2.5 percent. Thus, if the current recession had not occurred, the balance in the HI trust fund would have been higher, and its depletion would not be projected to occur quite so soon. But the basic financing problem of HI derives from the large gap between the rate of growth in hospital costs attributed to medicare beneficiaries and the earnings that are taxed to support HI.

C. MAGNITUDE OF THE TRUST FUND DEFICIT

The HI trust fund deficit is so large that treating the underlying problem of rapidly rising medical-care costs will probably have to be an important part of any long-run solution to medicare's financing problems. If costs are not controlled, a difficult choice between substantial retrenchments in the program and large tax increases will be necessary.

To gain an understanding of how large the HI deficits shown in tables 1 and 2 are, this section examines the trust fund impact of four medicare options that are often discussed:

—Increased hospital coinsurance.
—Prospective reimbursement.
—Payroll tax increases; and
—General revenue financing.

For each case, CBO has calculated the magnitude of the policy change required to maintain solvency and examined the implications of such changes. To simplify, the term "solvent" is used here to denote a trust fund balance that is not negative.

Many additional policy options are likely to be considered by the Congress when it takes up the long-term medicare financing issue, some of which may be preferred to the ones considered here. The options examined here to illustrate the magnitude of the financing problem were chosen because they are well known, the magnitude of their trust fund impact is relatively easy to estimate, and the degree of their stringency can be varied.

The projected differences between outlays and revenues are so large, however, that the illustrative options would have to be im-

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[9] For more detail, see Congressional Budget Office, "The Outlook for Economic Recovery" (February 1983), chapter III.

plemented with much greater degrees of stringency than is contemplated in current discussions. Combining a number of options would, of course, reduce the required stringency for any one option, but still leave each harsher than current discussions have contemplated—if not by 1995, then only a few years later.

1. Increased Coinsurance

Under current law, beneficiaries admitted to a hospital, pay a first-day deductible amount ($304 in 1983) once for each spell of illness; this deductible amount represents the average cost to medicare of a hospital day. Beyond that, they have no responsibility for the cost of medicare-covered services for the next 59 days. This deductible amount represents the average cost to medicare of a hospital day. Outlays could be reduced by requiring the beneficiary to pay a proportion of the cost of days after the first. The administration, for example, has proposed coinsurance for the second through 15th day of care equal to 8 percent of the deductible, and for the 16th through 60th day of care equal to 5 percent.[10]

Coinsurance, through a combination of transferring costs to beneficiaries and adding incentives to discourage hospital use, could reduce outlays enough to maintain solvency throughout the period under study (see table 3), but the amount required would be very large—much larger than the degree proposed in the President's budget. By 1995, a coinsurance rate of 36 percent of the deductible amount would be required (or 33 percent, if the TEFRA limits are extended).[11] If catastrophic protection were offered, or if low-income beneficiaries were required to pay only part of the copayment, the coinsurance rate would have to be substantially higher.[12] Alternatively, the same reduction in outlays could be achieved by a $167 monthly HI premium per enrollee. But either approach would require even greater cuts in benefits each year after 1995. Many would regard this as a major retrenchment in medicare's provision of both financial protection and access to care for the elderly and disabled.

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[10] See Budget of the United States Government, Fiscal Year 1984, p. 5-105. The administration also proposed to improve catastrophic coverage by limiting required deductibles and coinsurance to 60 days per calendar year.

[11] This estimate assumes that coinsurance reduces use of hospital services for those without private supplemental coverage or medicaid. The 36-percent rate discussed might reduce hospital days per capita for those without supplemental coverage by about one-third. The proportion of beneficiaries with private coverage would probably change in response to high coinsurance requirements, but the direction, let alone the magnitude, is difficult to predict. The analysis assumes that the proportion of beneficiaries with either private coverage or medicaid would remain unchanged.

The estimate also assumes that increased coinsurance would have no effect on the medical care system. By reducing medicare beneficiaries' use of hospital services, coinsurance might slow the rise in the cost of hospital care. This would lower the required coinsurance rate somewhat.

[12] For additional discussion of coinsurance options, see the forthcoming CBO study of the medicare benefit structure.

TABLE 3.—HOSPITAL COINSURANCE REQUIRED TO MAINTAIN SOLVENCY IN HI TRUST FUND THROUGH 1995, IN PERCENTAGES OF THE FIRST-DAY DEDUCTIBLE AMOUNT [1]

Calendar year	No extension of reimbursement limits [2]			Extension of reimbursement limits [2]		
	Coinsurance rate [3]	Average additional beneficiary liability [4]	Outlay reduction (billions of dollars)	Coinsurance rate [3]	Average additional beneficiary liability [4]	Outlay reduction (billions of dollars)
1987	9	$240	$7.6			
1988	14	400	12.9	10	$250	$8.1
1989	18	550	18.1	13	390	12.8
1990	21	725	24.2	17	550	18.3
1991	25	930	31.6	21	730	24.9
1992	28	1,150	40.0	24	940	32.5
1993	31	1,400	49.7	27	1,170	41.3
1994	33	1,690	60.9	30	1,420	51.4
1995	36	2,000	73.8	33	1,720	63.2

[1] While some working balances are required to pay claims in a timely manner, the definition of solvency used for this analysis is avoidance of a negative trust fund balance.
[2] See table 2 for definition.
[3] Percent of the 1-day deductible applied to second through sixtieth day of a spell of illness.
[4] Average over all beneficiaries. For those with a spell of illness, the average additional liability would be about four times the number in the table.

2. Prospective Reimbursement

Under prospective reimbursement, medicare would determine in advance the rate at which hospitals are paid. A major step in that direction was taken in TEFRA and, in a recent report to the Congress, then-Secretary of Health and Human Services Schweiker proposed a prospective system based on diagnostic related groups.[13]

Though the administration's prospective reimbursement proposal does not include enough detail to project its long-run impact on the HI trust fund, calculations similar to those for hospital coinsurance can be made to estimate how tight the prospective rates would have to be if negative trust fund balances were to be avoided. Maintaining solvency by prospective reimbursement alone would require hospital payments to average 42 percent less by 1995 than they would have been under cost reimbursement, or 38 percent less than if the TEFRA limits had been extended. Looked at from another viewpoint, if prospective reimbursement began in 1985 and the rates were set to require the same outlays as under TEFRA in that year, the rates per hospital admission could then increase at only the rate of general inflation (as measured by the "hospital market basket") less 1.6 percentage points per year. This would be 5 percentage points per year less than projected under cost reimbursement.[14]

The feasibility and desirability of such restraint in the growth of reimbursement is questionable. If prospective reimbursement were limited to medicare, a large gap would occur between what hospitals would get paid for serving private patients and what they would get paid for serving medicare patients. By making medicare

[13] See Richard S. Schweiker, "Report to Congress: Hospital Prospective Payment for Medicare," U.S. Department of Health and Human Services (December 1982).
[14] These estimates assume that prospective reimbursement would cover all costs including those for capital and for teaching. While current proposals such as the administration's exclude the latter two, most analysts regard their inclusion as necessary over the long term to avoid significant distortions in the use of capital.

patients financially unattractive to hospitals, this would reduce access. Hospitals might specialize, with some providing the standard of care permitted by private reimbursements, and others providing the lower standard of care permitted by medicare reimbursements.

Alternatively, prospective reimbursement could be applied to all payers, as is now done in a few States (for example Maryland and New Jersey) under waivers from medicare. In this case, the problem of two standards of care would be avoided, but the question of the desirability of the standard of care that is permitted by the reimbursement rates would have to be addressed. Though many analysts believe that economies could be found in hospital functions that would not sacrifice the quality of care, there is a point at which further rate reductions would lower the effectiveness of services.

3. Coinsurance and Prospective Reimbursement

Combining these two approaches could allow solvency to be maintained with lesser stringency in each. Combinations are possible because coinsurance tends to reduce the number of hospital admissions while prospective reimbursement reduces costs per admission. To the extent that each would shorten length of stay, however, the reduction in the stringency of each option if they were combined would not be so great as it might appear on the surface.[15]

If half of the required outlay reductions were obtained from each approach, the required coinsurance rate would be 18 percent by 1995, while the prospective rates per admission would increase by general inflation plus 1.6 percentage points per year.[16] The latter would represent an annual 1.7-percentage-point reduction from the rate projected under cost reimbursement.

4. Higher Payroll Tax Rate

Alternatively, HI solvency could be maintained by raising the payroll tax rate. Under current law, the HI tax paid by both employer and employees is scheduled to rise from its current rate of 1.30 percent of covered earnings to 1.35 percent in 1985, and to 1.45 percent in 1986. As is shown in table 4, maintaining solvency through tax increases alone would require a steadily increasing tax rate, reaching 2.54 percent by 1995, or 2.38 percent if the TEFRA reimbursement limits were extended.[17] The required rate would continue to increase thereafter. When added to the 6.2 percent tax rate now scheduled for the two social security trust funds that provide cash benefits, a payroll tax rate substantially larger than has been experienced in this country would be required, raising questions about employment and inflationary effects and about the impact on workers' take-home earnings.

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[15] If coinsurance reduced the average length of stay, then earlier discharge would be less available as an option to hospitals looking for ways to reduce costs in response to the incentives of prospective reimbursement.

[16] The required coinsurance rates and average liability per beneficiary can be obtained by taking one-half of the respective amounts in table 3.

[17] The calculations do not take into account any employment effects, or impacts on inflation, of the higher tax rates.

TABLE 4.—HI TAX INCREASES REQUIRED TO MAINTAIN TRUST FUND SOLVENCY THROUGH 1995, IN PERCENTAGES OF COVERED EARNINGS AND BILLIONS OF DOLLARS [1]

Calendar year	Current law tax rate [2]	No extension of reimbursement limits [3]		Extension of reimbursement limits [3]	
		Required tax rate	Additional revenues	Required tax rate	Additional revenues
1987	1.45	1.64	$7.6	1.45	
1988	1.45	1.75	12.9	1.64	$8.1
1989	1.45	1.85	18.1	1.73	12.8
1990	1.45	1.95	24.2	1.83	18.3
1991	1.45	2.06	31.6	1.93	24.9
1992	1.45	2.17	40.0	2.04	32.5
1993	1.45	2.29	49.7	2.15	41.3
1994	1.45	2.41	60.9	2.26	51.4
1995	1.45	2.54	73.8	2.38	63.2

[1] While some working balances are required to pay claims in a timely manner, the definition of solvency used to this analysis is avoidance of a negative trust fund balance.
[2] Percent of covered earnings paid each by employer and employee. Current rate is 1.30 percent, scheduled to increase under current law to 1.35 percent in 1985 and 1.45 percent in 1986.
[3] See table 2 for definition.

5. General Revenue Financing

Instead of a higher payroll tax rate, general revenues could be used to make up the difference between currently scheduled revenues and outlays. Given the deficit problem in the Federal budget as a whole, however, and the large size of the required infusion of revenues—$73.8 billion per year by 1995 ($63.2 billion if the TEFRA limits are extended) and more each year thereafter—this option would require increased general tax revenues. Thus, the major differences between raising the HI tax rate and using general revenue financing would come down to who pays the additional taxes.[18]

6. Increased Coinsurance, Prospective Payment, and Higher Payroll Tax Rates

Less stringent versions of these three options could be combined o achieve trust fund solvency. If each closed one-third of the gap between outlays and revenues, the required coinsurance rate would be 12 percent by 1995, the prospective reimbursement formula would allow payments per admission to increase by general inflation plus 2.4 percentage points per year, and the HI tax rate would be 1.76 percent by 1995.

D. CONCLUSION

Under current law, balances in the HI trust fund are expected to be depleted by 1987 or 1988. Because the cumulative projected deficit is so large—$300 to $400 billion by 1995—maintaining solvency through 1995 will require substantial policy changes. Avoiding deficits through policies to reduce outlays would require actions significantly more stringent than any being discussed today. Alternative-

[18] A comparison of the relative merits of payroll taxes versus general revenues is beyond the scope of this memo. For a discussion, see John A. Brittain, "Payroll Taxes for Social Security," Brookings, 1972.

ly, taxes could be increased, but the magnitude of the rate increases would have to be very large. Even solving the medicare financing problem by combining a number of such options would require greater changes than many observers now contemplate.

Alternatively, steps might be taken outside of the program to slow the rate of increase in medical costs. This, in turn, would reduce the magnitude of the required program changes. Possible measures range from those that would increase the degree of competition between medical providers—such as changing the tax treatment of employer-paid health insurance—to more comprehensive regulation than prospective reimbursement applied to all payers. To solve the problem in this way, however, would also require bolder measures than contemplated today.

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